STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675089	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Sherman	817 W Center Sherman, TX 75090

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49837 Based on interview and record review, the facility failed to implement written policies and procedures that prohibit mistreatment, neglect, and abuse for two (Resident #2 and an unknown Resident) of four residents reviewed for abuse. The facility did not implement their policy on reporting abuse to state agency for a resident-to-resident altercation that occurred on 12/13/24 between Resident #2 and an unknown Resident. This deficient practice could place residents at risk for abuse, neglect, and not having their needs met. Findings included: Record review of the facility policy titled Abuse revised on 01/01/2023, reflected, Reporting/Investigation: The law requires the abuse coordinator/designee, or employee of the facility who believe that the physical or mental health or welfare of a resident has been or may be adversely affected by abuse, neglect, or exploitation caused by another person to report the abuse, neglect or exploitation .All events that involve an allegation of abuse or involved a suspicious serious bodily injury of unknown origin must be reported immediately or not later than 2 hours of the alleged violation .Protection: It is of utmost importance that a resident(s) suspected of being abused, and other residents must be protected during the initial identification, and investigation process . Record review of Resident #2's face sheet, dated 03/12/25, reflected Resident #2 was a [AGE] year-old female, originally admitted to the facility on [DATE] with a diagnosis which included traumatic subarachnoid hemorrhage (stroke caused by bleeding on the surface of the brain), oropharyngeal phase (difficulty swallowing), altered mental status and dementia. Record review of Resident #2's quarterly MDS assessment, dated 01/08/25, reflected Resident #2 had a BIMS of 8, which indicated her cognition was moderately impaired. The MDS reflected Resident #2 had physical and verbal behaviors directed toward others. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's comprehensive care plan revised 12/31/24, reflected Resident #2 had a Focused area of behavior problem related to low frustration tolerance .history of hitting, propelling wheelchair at a fast pace and running into other residents, grabbing, and screaming at staff, takes off colostomy bag (medical device that collects stool from the body)) and throws it on the floor. The care plan interventions included: administer medications as ordered, monitor and document for side effects and effectiveness, if reasonable, discuss resident's behaviors, intervene as necessary to protect the rights and safety of others, approach and speak in a calm manner, divert attention, psych notification for PRN evaluation for increased behaviors, and remove from the situation and take to alternate location as needed. Record review of the facility incident reports for 3 months (12/12/24-3/12/25), did not reveal any incidents involving Resident #2 and an unknown Resident on 12/13/24. Record review of LVN H written nurse's notes dated 12/13/24 reflected, LVN H was standing out at the med cart in the hall when we heard shouting. Get off me! shouted [Resident #2.] LVN H turned around and witnessed [Resident #2] hitting another resident . LVN H immediately walked over to [Resident #2] and educated her about keeping her hands to herself. [Resident #2] started repeating I'm sorry. LVN H asked [Resident #2] to apologize to the resident she hit. [Resident #2] did. In addition, review of LVN H notes revealed no assessed for Resident #2. In an interview on 03/12/25 at 11:18 a.m. with Resident #2 revealed she denied she hit anyone. She denied she was in an altercation with anyone. In an attempted phone interview on 03/13/25 at 1:50 p.m. with LVN H, left voice message for LVN H to call back the writer . The writer received no returned call prior to the survey exit. In an interview on 03/13/25 at 2:49 p.m. with RN J, revealed she had no knowledge of the 12/13/24 incident that involved Resident #2 and an unknown resident. RN J revealed she knew what the abuse reporting policy was. RN J revealed any abuse is to be reported to the abuse coordinator/administrator within 24 hours unless it involves serious bodily injury, then you would report it within 2 hours. In an interview on 03/13/25 at 3:06 p.m. with CNA I, revealed she had no knowledge of the 12/13/24 incident that involved Resident #2 and an unknown resident . CNA I revealed any abuse or neglect is to be reported to the charge nurse and administrator immediately. In an interview on 03/13/25 at 3:36 p.m. the DON stated she was unaware of the unreported incident. She stated the incident should have been reported per the facility policy. She stated her expectations is for her staff to report all incidents of abuse and neglect within the timeframes per the policy. She stated facility staff is aware of the facility's reporting protocols , which was provided in their trainings. She stated she is responsible for staff trainings on abuse and neglect and reporting policy. She stated failure to report could place other residents at risk for injury or harm. In a phone interview on 03/13/25 at 4:28 p.m., the Administrator stated he was the abuse coordinator for the facility. The Administrator stated he was unaware of the unreported incident. The Administrator stated his expectations is for his staff to report all incidents of abuse and neglect within the timeframes per the facility policy. The Administrator stated it was important to report any allegations of abuse and neglect for safety and protection of the residents and try to circumvent other incidents of abuse .

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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** 34399 Based on observation, interview and record review the facility failed to ensure the resident environment remained as free of accident hazards as possible and failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 4 residents (Resident #1) reviewed for accidents and hazards. The facility failed to ensure adequate supervision and put measures in place to prevent Resident #1 who was at risk for eloping from the facility. Resident #1 had history of confusion, exit seeking behavior and wandering behavior. On 12/20/24, Resident #1 eloped out of the facility and the facility was not aware the resident eloped. Resident #1 was walking the streets about 3 blocks away from the facility in a residential area. The noncompliance was identified as PNC. The IJ began on 12/20/24 and ended on 12/26/24. The facility had corrected the noncompliance before the survey began. These failures could place residents at risk of potential accidents, injuries, harm or death. Findings include: Review of Resident #1's face sheet undated reflected Resident #1 was admitted to the facility on [DATE] from another skilled nursing facility with diagnoses of Muscle Wasting and Atrophy (significant shortening of the muscle fibers and loss of overall muscle mass), Syncope and Collapse (fainting), Dementia (loss of cognitive functioning that interferes with daily life and activities), Depression, Alzheimer's disease (brain disorder that slowly destroys memory and thinking skills), Glaucoma (eye disease that can cause vison loss and blindness and blindness), Hypertension, Osteoarthritis (chronic degenerative joint disease), Generalized Muscle Disease, Unsteadiness on feet, lack of coordination and cognitive communication deficit. Resident #1 was not her own responsible party. Review of Resident #1's Admission MDS dated [DATE] reflected Resident #1 had a BIMS of 7 indicating she was severely cognitively impaired. Resident #1 had wandering behavior daily. Resident #1 was independent with ambulation with no assistive devices. Resident #1 required supervision with ADLs except she required partial/moderate assistance with bathing. Review of Resident #1's Admitting paperwork from previous facility discharge summary reflected: [Resident #1] has cognitive impairments and requires redirection for orientation, care and safety. [RP] would like to secure placement in a long-term care facility that can assist with redirection for wandering/exit seeking and a secure unit as needed. Review of Resident #1's baseline care plan dated 12/06/24 reflected Resident #1 was an elopement risk. Resident #1 was cognitively impaired due to forgetfulness and dementia. Review of Resident #1's Comprehensive Care Plan dated 12/20/24 reflected the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-dated 12/20/24 Resident #1 had impaired cognitive function or impaired thought processes related to impaired decision making abilities, is not always understand or able to understand verbal and non-verbal expression related to dementia. -revised 12/31/24 Resident #1 is an elopement risk/wanderer and is at risk for possible injury [related to] impaired safety awareness and diagnosis of dementia 12/20/24 Resident had elopement event. Interventions included Distract resident from wandering ., Provide structured activities ., secure unit placement for increased monitoring. -revised 02/06/25 Resident #1 resides on the facility security unit [due to] wander/elopement risks related to history of attempts to leave facility unattended, impaired safety awareness, resident wanders aimlessly. Interventions included Identify pattern of wandering: Is wandering purposeful, aimless or escapist? .Intervene as appropriate. Review of Resident #1's Incident Report dated 12/20/24 reflected elopement incident for Resident #1. It reflected received phone call that resident was at a nearby house. Resident of the home was able to retrieve this resident's cell phone and call resident's[RP]. [RP] picked resident up and returned resident to facility. Resident states 'the girls and I went to a dance and got lost. Head to toe assessment performed, with no injuries noted. Resident on one-on-one monitoring until moved to secure unit on this day .Admin initiated self-report. Medical Director informed. Resident #1 was oriented to person only. Resident #1 had predisposing physiological factor s of confused and impaired memory. Review of Resident #1's 24 Hour report dated 12/20/24 reflected Resident #1 elopement 12/20/24. One to one monitoring until moved to unit moved to 509B. Observation and Interview on 03/12/25 at 10:28 AM revealed Resident #1 was sitting on her bed in her room on the secure unit. Resident #1 was confused and could not recall the incident. She stated she felt safe at the facility. Review of Resident #1's progress note for December 2024 reflected the following: Dated 12/05/24 12:45 PM by RN A resident admitted to facility ambulatory has dx of dementia and wondering alzheimers .very pleasant oriented to room .will continue to monitor and assess will update [medical doctor] family and admin prn status changes. Dated 12/06/24 12:40 PM by LVN B Resident exit seeking and attempting to exit out of 200 hall exit door. Resident redirected to eat lunch. Dated 12/06/24 1:55 PM by LVN B Resident continuing to attempt to exit seek. Resident pushing on exit doors. Staff attempting to redirect resident. Resident confused. [Alert and Oriented] x1. DON notified. Review of Incident/Accident Reports December 2024 to March 2025 reflected no other elopement incidents for any other residents in 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	Interview on 03/12/24 at 1:54 PM with LVN C revealed Resident #1 eloped on 12/20/24 but he was not working when the incident occurred. He stated Resident #1 was confused, had wandering behavior and would ask about leaving the facility. He stated he had been in-serviced after the incident in December 2024 on elopement policy, signs/symptoms of residents at risk for elopement. He was knowledgeable about his role as a charge nurse for a missing resident. He stated Resident #1 was placed on the secure unit after the elopement incident. Interview on 03/12/24 at 3:22 PM with LVN B revealed Resident #1 had expressed desire to go home constantly, would say her family member was coming to pick her up, and asked LVN B what door do I exit from. She stated she would redirect Resident #1 when she expressed wanting to leave and go home. She stated on the morning of 12/20/24 before the incident Resident #1 was confused and did not understand why she was at facility. She stated Resident #1 required redirection and distraction from wanting to leave. She stated on 12/06/24 Resident #1 did have 2 occurrences of exit seeking on pushing on hall 200 doors and she documented it in the nurse's note. She stated she redirected Resident #1 when she attempted to exit seek and distracted her. She stated she was not aware of Resident #1's history if she was an elopement risk upon admission. She stated on 12/06/24 she was not Resident #1's charge nurse and could not recall who she notified about the exit seeking behavior for Resident #1. She stated she was in-serviced after the incident in December 2024 on elopement policy, signs/symptoms of residents at risk for elopement and completing elopement assessment. She was knowledgeable about her role as a charge nurse for a missing resident. She was unaware of any elopement incidents since Resident #1's elopement on 12/20/24. Follow-up Interview on 03/13/25 at 10:15 AM with LVN B revealed on 12/20/24 Resident #1 was last seen at the facility's Christmas party at 1:45 PM or 2 PM. She stated 2:00 PM is shift change so she was not working when Resident #1 returned to the facility after the elopement. She stated she documented Resident #1's exit seeking behavior on 12/06/24 in a nurse's note since she was not Resident #1's charge nurse. Interview on 03/12/24 at 3:40 PM with MDS Coordinator revealed Resident #1 admitted from another skilled nursing facility. She stated Resident #1 did have wandering behavior and the baseline care plan reflected she was at risk for elopement. She could not find an elopement assessment upon admission for Resident #1. She stated she was not working the day of Resident #1's elopement. She stated the charge nurse who admits a resident was responsible to ensure elopement assessment completed to determine resident's elopement risk level. She stated she was in-serviced after the incident in December 2024 on elopement policy and signs/symptoms of residents at risk for elopement. Interview on 03/13/24 at 8:45 AM with RN A revealed Resident #1 was oriented to her self only but confused about the place. Resident #1 was ambulatory and wandered within the facility. She stated Resident #1 would go to the door but was not aware of her attempting to exit prior to the elopement. She stated Resident #1 was a risk for elopement due to confusion and wandering behavior. She stated she was the admitting nurse for Resident #1 and she could not recall why elopement assessment was not done at admission. She stated she could not recall reviewing Resident #1's discharge paperwork from the previous facility. She was not aware Resident #1 was an elopement risk. She stated she was not aware Resident #1's baseline care plan showed Resident #1 as an elopement risk. She stated the DON was the charge nurse at time of elopement incident for Resident #1. She stated she was in-serviced after the incident in December 2024 on elopement policy, signs/symptoms of residents at risk for elopement. She stated after being in-serviced she was aware all residents upon admission should have elopement assessment completed to determine elopement risk. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 03/13/25 at 9:25 AM with CNA D revealed Resident #1 was confused and would misplace her phone asking for assistance from facility staff to find it. She stated Resident #1 had occasional exit seeking behavior of going towards the exit doors. She stated Resident #1 constantly wandered within the facility and would ask to go to go with Resident #1's RP. She stated nurses were aware of Resident #1's wandering, confusion and exit seeking behavior. She stated Resident #1 was placed on the secure unit after the elopement incident. Interview on 03/13/25 at 9:32 AM with Med Aide E revealed she did could not recall Resident #1 prior to being on the secure unit and did not recall elopement incident for Resident #1 in December 2024. She stated Resident #1 was currently on the secure unit for resident safety. She stated she had been in-serviced on elopement policy and signs/symptoms of residents at risk for elopement. Interview on 03/13/25 at 9:55 AM with Resident #1's RP revealed at the previous facility she exhibited behavior of wandering and would go to the exit doors to look out. She stated Resident #1 was confused and had dementia. She stated Resident #1 had not eloped at previous facility but they had Resident #1 moved to this facility for the resident safety and risk for elopement. She stated she had not had a care plan meeting with the facility. She stated nursing had not reached out to her prior to this incident of any exit seeking behavior for Resident #1. She stated she did not meet with facility staff to review the baseline care plan and facility had not discussed with her secure unit until after this elopement incident. She stated on 12/20/24 when she was shopping at a local store she received a phone call from a stranger using Resident#1's phone informing Resident #1 was walking the streets in a residential area. She stated she responded by telling the stranger the resident could not be there she was a resident at the facility. She stated she immediately left to go get Resident #1. She attempted to call the facility and was not able to get through but called a friend who called the facility to inform them Resident #1 was found walking the streets. She stated when she got to Resident #1 it was about like 10 minutes from when she first received the phone call. She stated she found her about 3 blocks away from the facility in a black sweatshirt with pants, socks and shoes on. Resident #1 told her she was dancing with her friends and got lost. She stated Resident #1 was cold and shivering with a blanket covering her provided by the bystander. She stated the bystander told her Resident #1 had flagged them down on the street saying she knew them and was walking the streets in residential area. She stated the facility had informed her later she must have gone out the door after the Christmas party when other visitors were exiting. She stated she took Resident #1 back to the facility in her car and nurse assessed her. She stated Resident #1 was not injured and was mad when Resident #1's RP left. She stated Resident #1 was placed on the secure unit after the elopement incident. Interview on 03/13/25 at 10:29 AM with CNA F revealed she saw Resident #1 at the facility's Christmas party eating but she had to leave about 2 pm to transport another resident to an appointment. She stated Resident #1 did have exit seeking behavior and would express her desire to leave the facility especially after her family would visit. She stated she had been in-serviced after Resident #1's elopement on elopement policy, signs/symptoms of residents at risk for elopement, abuse/neglect. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 03/13/25 at 10:48 AM with Activity Director revealed on 12/20/24 facility had a Christmas party in the dining room including facility staff, residents and visitors from 1:30 PM to 2:00 PM. She stated she saw Resident #1 at the Christmas party but she did not recall seeing her after that. She stated she was not at the facility when Resident #1 returned to facility after elopement incident later that day. She stated Resident #1 was ambulatory on her own, had some confusion and looked like a visitor. She stated she was not aware of Resident #1 exit seeking behavior. She stated there was like 60 people at the Christmas party and maybe she had followed visitors out the door after the party. Interview on 03/13/25 at 10:35 AM with CNA K revealed she was knowledgeable on elopement policy, signs of residents with elopement risk, abuse/neglect and would immediately report to Charge Nurse, Administrator and DON if a resident was found missing. She had been recently in-serviced on elopement protocol and abuse/neglect policy. Interviews on 03/12/25 at 1:21 PM and 03/13/25 at 11:45 AM with CNA G revealed she had been recently in-serviced on elopement policy and signs of residents with elopement risk. She was aware she needed to notify Charge Nurse, Administrator and DON when resident is found missing. She was knowledgeable of types of abuse/neglect and had been in-serviced on abuse/neglect recently. Interview on 03/13/25 at 11:28 AM with ADON revealed she was working today as a charge nurse and works the floor as needed as the charge nurse. She stated she was in-serviced on elopement protocol including signs of residents at risk for elopement and the nurse's role when resident is found missing. She stated she had been in-serviced on nurse responsibility to complete elopement assessment upon admission and as needed when resident exhibits exit seeking behavior. She stated when Resident #1 eloped she was at risk of injury. Interviews on 03/13/25 at 12:10 PM with LVN L revealed she worked 2 pm to 10 pm shift on 12/20/24 but was not the charge nurse for Resident #1. She stated she was unaware of resident elopement risk and had not witnessed any exit seeking behavior from Resident #1. She stated Resident #1 was ambulatory on her own and did look like a visitor. She stated Resident #1 had confusion. She stated she was in-serviced after the incident in December 2024 on elopement policy, signs/symptoms of residents at risk for elopement and completing elopement assessment. She was knowledgeable about her role as a charge nurse for a missing resident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 03/13/25 at 1:13 PM with DON revealed she was unable to provide any witness statements of Resident #1's elopement. She stated she was the charge nurse for Resident #1 on 2 pm to 10 pm shift on 12/20/24. She received a phone call from a friend to Resident #1's RP who also worked for the facility that Resident #1's RP had received a phone call from a stranger that Resident #1 was found at a neighboring house. The DON looked at incident report and stated she had received the phone call at 3:45 PM on 12/20/24 because this is when she initiated the incident report for Resident #1. She stated Resident #1's RP brought Resident #1 back to the facility and Resident #1 was confused saying she went dancing with her friends. She stated she assessed Resident #1 head to toe with no injury noted. She could not recall the specific vitals but stated Resident #1's vitals were within normal limits. She stated facility initiated 1:1 for resident safety when she returned and after consent placed her on the secure unit for exit seeking behavior and elopement incident. She stated when interviewing staff after the elopement Resident #1 was last seen by staff at Christmas party on 12/20/24. She stated Resident #1 did wander within the facility but she was not aware of any exit seeking behavior. She stated when she reviewed Resident #1's progress notes she found the note on 12/06/24 stating Resident #1 had exit seeking behavior and stated she was not made aware of it. She stated she completed the baseline care plan for Resident #1 and stated she put down Resident #1 was an elopement risk based on previous stay at skilled nursing facility. She stated she did not review the baseline care plan with Resident #1's RP and did not look to see if elopement assessment had been completed upon admission. She stated she completed Resident #1's elopement assessment after the incident on 12/20/24 indicating she was high elopement risk due to elopement. She could not recall discussing secure unit placement with Resident #1's RP until after she had eloped on 12/20/24. She stated nursing had been in-serviced on completing elopement assessments upon admission and as needed when residents exhibit exit-seeking behavior. She stated if she had been made aware of Resident #1's exit seeking behavior on 12/06/25 she stated an elopement assessment would have been completed to determine elopement risk and to discuss with team about secure unit placement for safety. She stated the potential risk of elopement was serious injury or accident for Resident #1. She stated Resident #1 had intermittent cognition especially after Resident #1's RP visited and did not understand why she was placed at facility. Interview on 03/13/25 at 1:55 PM with Administrator revealed Resident #1's Previous Facility expressed she would go to the exit door asking about a car. He was not aware of Resident #1 having exit seeking behavior until after elopement incident in December 2024. He stated facility investigation revealed Resident #1 was last seen at the Christmas party on 12/20/24 and may have exited behind visitors or other people at the end of the party. He stated Resident #1 did elope and was immediately placed on 1:1 with staff until placed on secure unit for elopement and resident safety. He stated there have been no other elopements. He stated if he was aware of the exit seeking behavior prior to incident they could have assessed her with elopement assessed and review to determine if she required more supervision. He stated the potential risk to Resident #1 could be injury and serious harm. He stated the facility completed an elopement drill with facility staff to ensure staff were knowledgeable of facility policy on elopement. Review of staff In-services reflected: 12/20/24 and 12/26/24 staff in-serviced on elopement education including elopement drill 12/26/24 nurses in-serviced on completing all admission assessments by DON included RN A, LVN B, LVN C, ADON, MDS Coordinator and other nurses. (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	12/20/24 and 12/28/24 staff in-serviced on abuse/neglect Review of facility's policy Elopement dated 11/01/19 reflected To safely and timely redirect patients/residents to a safe environment. A prompt investigation and search will be conducted if a patient/resident is considered missing .6. When the patient/resident is located, the nurse completes a head-to-toe assessment. The social service designee assesses the patient/resident for emotional distress. Elopement occurs when a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so. A resident who leaves a safe area may be at risk of (or has the potential to experience) heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle. Examples of criteria that put a resident at higher risk of elopement .Cognitive impairment (example: those who dementia, Alzheimer's, brain injury) Exit-seeking behaviors (example: confused resident that thinks he/she needs to go pick their kids up from the school) New admission wanting desperately to leave .History of elopement at other communities Review of facility's policy Elopement Risk assessment dated [DATE] reflected facility will assess all patients/residents for elopement potential in order to provide a safe and comfortable living environment. PROCEDURE 1. All patients/residents are assessed on admission by a licensed nurse for elopement risk utilizing the elopement risk assessment form. 2. All patients/residents are re-assessed for elopement potential by the licensed nurse/social service designee quarterly throughout a patient's/resident's stay and with a significant change .4. The licensed nurse or social service designee completes the elopement risk assessment form and presents to the interdisciplinary team for further intervention.6. The physician and the patient/resident or the patient's/resident's representative are notified of the patient's/resident's risk for elopement and the interventions that are recommended for prevention of elopement and patient/resident safety. 7. The patient's/resident's legal representative should be contacted, if possible, to obtain all pertinent information in relation to elopement risk .10. A licensed nurse documents in the nurse's notes and behavior monitoring flow record any exit seeking behavior on an on-going basis and interventions are adjust as needed. 11. A baseline plan of care should be completed on admission and any elopement risks should be identified. The DON and Administrator were notified and provided the IJ template on 03/13/25 at 6:05 PM of PNC IJ for F689. The DON was provided the IJ template for PNC F689 on 03/13/25 at 6:05 PM. The IJ began on 12/20/24 and ended on 12/26/24. The facility had corrected the noncompliance before the survey began