STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675329	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Levelland Nursing & Rehabilitation Center	210 West Ave Levelland, TX 79336

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43150 Based on interview and record review, the facility failed to inform residents in advance of the risks and benefits of proposed care and treatment for 3 of 3 resident reviewed for resident rights. (Resident #1, Resident #2, and Resident #3) The facility failed to ensure consents from responsible parties were given to place wander guard bracelets on Resident #1, Resident #2, and Resident #3. This failure could place residents at risk for receiving psychoactive medications without consent and knowledge of side effects. Findings included: Resident #1: Record Review of Resident #1's face sheet dated 03/20/25 revealed a [AGE] year-old male with an original admitted [DATE] and a readmitted [DATE] with the following diagnoses: bacterial pneumonia (a serious lung infection caused by bacteria), metabolic encephalopathy (an acute condition of global cerebral dysfunction in the absence of primary structural disease), type 2 diabetes mellitus, hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid hormone), high blood pressure, hyperlipidemia (a condition in which there are high levels of fat particles in the blood), dementia, abnormalities of gait and mobility, lack of coordination, repeated falls, muscle weakness, acute kidney failure, psychotic disorder with hallucinations. Record review of Resident #1's Annual MDS (Minimum Data Set) assessment dated [DATE] revealed: He had a BIMS (Brief Interview for Mental Status) listed as 3, he had long and short-term memory impairment with severely impaired cognitive skills for daily decision making. Record review of Resident #1's Care Plan, dated 01/10/2025, revealed that Resident #1 was not care planned for wander guard. Review of Resident #1's Care Plan updated 8/13/24 revealed: Showed to be (dependent on staff etc.) for meeting emotional, intellectual, physical, and social needs r/t Cognitive deficits, Immobility. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675329	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2025
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #2: Record Review of Resident #2's face sheet dated 03/20/25 revealed a [AGE] year-old female with an original admitted [DATE] and a readmitted [DATE] with the following diagnoses: seizures, intellectual disability, Microcephaly (a condition in which a baby's head is significantly smaller than expected often due to abnormal brain), scoliosis, osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bones wear down, depression, hyperlipidemia (a condition in which there are high levels of fat particles in the blood). Record review of Resident #2's Annual MDS (Minimum Data Set) assessment dated [DATE] revealed: He had a BIMS (Brief Interview for Mental Status) listed as 3, he had long and short-term memory impairment with severely impaired cognitive skills for daily decision making. Record review of Resident #2's Care Plan, dated 01/10/2025, revealed that Resident #2 was not care planned for wander guard. Resident #3: Record Review of Resident #3's face sheet dated 03/20/25 revealed a [AGE] year-old male with an admitted [DATE] with the following diagnoses: dementia, chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), acute kidney disease (a condition in which the kidneys suddenly cannot filter waste from the blood), urinary incontinence, high blood pressure, acid reflux, osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bones wear down). Record review of Resident #3's Quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed: He had a BIMS (Brief Interview for Mental Status) listed as 3, he had long and short-term memory impairment with severely impaired cognitive skills for daily decision making. Record review of Resident #3's Care Plan, dated 01/10/2025, revealed that Resident #3 was not care planned for wander guard. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/20/2025 at 11:35 AM, LVN D stated that the steps to do a wander guard had depended on if resident was an elopement risk. LVN D stated that they would have to do a wandering assessment. LVN D stated that the Wandering Assessment would let you know if the resident was high risk. The nurse initiates the risk assessment. LVN D stated that Resident #1 had wanted to get out the day he eloped. LVN D stated that Resident #1 had tried to get out of the door. LVN D stated that she had put a wander guard on the resident when he tried to get out the first time. LVN D stated that she was unsure of the actual date. LVN D stated that they had used PCC (point click care) for the assessment. LVN D stated that she had done the assessment and had gotten a wander guard to put on the resident. LVN D stated that the assessment had showed that the resident needed the wander guard. LVN D stated that she had done the wander guard first and then she had done assessment. LVN D stated that she had reported to the oncoming nurse that she had placed a wander guard on the resident. LVN D stated that she had notified the DON, Administrator, and the ADON when she had placed the wander guard on Resident #1. LVN D stated that no one had ever reported to her that he had attempted to get out. LVN D stated that she had done her assessment based on what she observed. LVN D stated that she had not seen Resident #1 get out but when she was leaving when she was told that the resident had gotten out. LVN D stated that Resident #1 was found outside and had fallen in the front. LVN D stated that she had done an elopement training. LVN D stated that she had been trained to announce it and everyone needs to start looking. LVN D stated that the charge nurse would have been the one stationary person to report back to. LVN D stated that she would have reported to the Administrator, DON, and then after 15 minutes would need to notify the police and call the family. During an interview on 03/20/2025 at 6:05 PM, Physician stated that the facility may have notified his Nurse Practitioner about the elopement. Physician stated that he did not know if Resident #1 had a wander guard. Physician stated that Resident #1 had no elopement issues that he knew of. During an interview on 03/20/2025 at 6:13 PM, Family Member #2 stated she did not know the exact date, but she was told Resident #1 had gotten out the front door. Family member #2 did not say how far Resident #1 had gotten. Family member #2 stated that it was told to her in the day that Resident #1 had managed to get out the front door. Family member #2 stated that she was not sure if it was LVN D or LVN E that had notified her. Family member #2 stated that Resident #1 did not have his wander guard and had not had it for a while, it had been several weeks. Family member #2 stated that she did not know why they had taken the wander guard off. Family member stated that the facility did not notify them of the wander guard being taken off the first time or that they had placed one on Resident #1 the day he had eloped from the facility. Family member #2 stated that after Resident #1 had fallen, the day that he eloped and had fallen outside, they had put the wander guard back on Resident #1. Family member #2 stated that it was observed that it was off but had never asked, and just assumed it was because Resident #1 quit wandering and never questioned it. Family member #2 stated that they had noticed the wander guard, but no one had mentioned putting it back on Resident #1. Family member #2 stated that she had seen Resident #1 the next day and noticed that they had placed the wander guard back on. Family member #2 stated that their concern was Resident #1 was at the back of the building. Family member #2 stated that Resident #1 had to walk down a long hallway to get out of the building. Family member #2 stated that no one had paid attention and noticed it, and this is concerning. Family member #2 stated that their parking lot was right by the street. Family member #2 stated prior to this incident they never had concern about Resident #1's care, until this. Family member #2 stated that they were fine with the placement of the wander guard but if they had been told that they were going to take it off they would have declined for the safety of Resident #1, it never was an issue. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/20/2025 at 6:35 PM, NP stated that she was notified on 03/10 that Resident #1 was trying to get out the front door and that he gotten out, right outside the door. NP stated it was her understanding that Resident #1 had not even gotten to the sidewalk. NP stated she was unaware that he gotten to the parking lot near the street. NP stated she received a text stating that they had put a wander guard on Resident #1 on 3/10. NP stated that she does not know if it was before or after he had actually eloped. NP stated her text that she had received stated I put a wander guard on Resident #1 because he was trying to get out of the building after lunch. The NP stated she had not had a text message that had showed that he had gotten out of the facility. NP stated she was unaware if Resident #1 had a wander guard prior to the placement on 03/10. NP stated she had never given an order for a wander guard to be taken off. NP stated they do notify her if they take it off and she has not had any notifications that one needed to be taken off of Resident #1. NP stated that they would have to had justification to take the wander guard off and put on. NP stated that she had a text on August 13 of 2024 that Resident #1 had tried to get out. NP stated that she did not know who texted because the number was not saved. NP stated that she had located the text says Resident #1 had gotten out. NP stated that she thought it was right outside of the door because she received a phone call letting her know they gotten Resident #1 back in. NP stated that when she calls about elopements and wander guard placements she will ask them what symptoms the resident had been having and what is the reason. NP stated that she had not received that information with Resident #1's case. NP stated that it was normal to have placed a wander guard after one attempt especially with Resident #1's case because the doors are unlocked from 7-8 PM. NP stated that it was case dependent in how they respond to elopements. NP stated it was situational. NP stated that in that facility it is almost impossible to actually monitor the front door and where the patient was going. NP stated that there was no way of watching that. NP stated that the wander guard was important because of the layout of the facility. NP stated that Resident #1 cannot walk fast, but fast enough. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/21/2025 at 12:00 PM and continued on 03/24/2025 at 6:17 PM, the Administrator stated that she had been in the facility since November 2024 and that if Resident #1 had a wander guard it would have been documented. The Administrator stated that if Resident #1 were placed on 1:1, it would have been documented and an order for the increased supervision. The Administrator stated that they would have completed an assessment first before placing the wander guard. The Administrator stated that they would also have to have an order to remove a wander guard. The Administrator stated that with Resident #1 eloping successfully, after he had already attempted, could have been prevented. The Administrator stated that Resident #1 had showed signs of wanting to leave and the facility failed to place him on 1:1 supervision. The Administrator stated that she did provide an elopement in-service. The Administrator stated that, Everyone is responsible for keeping the resident safe. The Administrator stated, I was told that they had completed the assessment first and then had called for a wander guard. The Administrator stated that it could be considered a restraint. The Administrator stated that LVN D had documented that Resident #1 had went to the door. The Administrator stated that the assessment would tell you if the Resident needed a wander guard. The Administrator stated that the guard will not stop the resident from getting out of the door, but it is an intervention. The Administrator stated that there is not a reason the assessment is done after the placement. The Administrator stated that she had not had anything on a 24-hour report for Resident #1. The Administrator stated that she did an investigation. In her investigation she had not seen wander guard from any time before. The Administrator had not seen the high risk on all wandering assessments. She stated she did not look at the progress notes or assessments as a part of her investigation. The Administrator stated that she had not talked to the family since the elopement. She stated her team did tell her that they had notified the family. The Administrator stated that she did not follow up to check if the family had been notified. The Administrator stated that even in self-report all that was told to her was that the family was notified. The Administrator stated that she was unaware that the family had not been notified. The Administrator stated that the facility system to monitor incident and accident prevention was to review risk management daily and take the information from morning meetings and address as they are reported. The Administrator stated that she had been trained on incident and accident prevention. The Administrator stated they would have needed need to complete an assessment and then they would have to score a certain score, notify physician, notify family, sign the consent, before it could even be placed. It also would come with restrictions such as how often you would use it or when you remove it. The Administrator stated yes she was familiar with the policy for placing a wander guard. The Administrator stated that the purpose of a consent specifically for restraints is the responsible party was consenting and good form of notification. The Administrator stated that the negative potential outcome of not obtaining a consent for a restraint would be a dignity concern. She stated that the family could have a concern for restraining. The Administrator stated that she was not aware that a consent was not in place but was aware now and all consent have been completed and in place. The Administrator stated that she was not aware that the assessment was completed after the restraint was placed on the resident, and once the IJ happened she learned of the situation. The Administrator stated that the system for monitoring for restraints was that she monitors when one is placed and would make sure DON had made her aware when one is placed, and she would follow up and have ADON monitor every week. The Administrator stated that she had been trained in restraints and her staff does complete orientation and annually as well. The Administrator stated that she had observed these residents (Resident #1, Resident #2, and Resident #3) with a wander guard on. The Administrator stated that her expectations in regard to restraint placement was that we are following our policy and that we are completing proper assessments before applying. The Administrator stated it was the responsibility of the charge nurses to apply restraints and complete assessments, and the responsibility of the ADON and DON to monitor. The Administrator stated that everyone was responsible for following the policy. The Administrator stated that there was no reason the assessment was completed after the placement of the wander guard as it relates to Resident #1, she thinks the nurse just wanted to be initiative-taking and was too initiative-taking. The Administrator stated that there was no reason a consent was not obtained from the family rep before the placement of the wander guard for Resident #1 and Resident #2. The Administrator stated that all consents and elopement risk assessment are in place and current.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/21/2025 at 12:22 PM, The DON stated that the facility had failed to prevent incident and accident allowing Resident #1 to get out. The DON stated, I was in my office and was told that he was at the door. The DON stated that the incident had prompted the wander guard situation. The DON stated that Resident #1did not get out of the door but he was at the door. The DON stated that she spoke with LVN D and was told that Resident #1 had not gotten out of the door. The DON stated that she had spoken to Occupational Therapist A and was under the understanding that Occupational Therapist A was there with Resident #1 at the door the first time. The DON stated that Resident #1 had not exhibited any signs of wanting to leave the facility to her knowledge, prior to the elopement. The DON stated that after the incident had happened she did not talk to the aides to see if Resident #1 had exhibited any signs prior to the elopement. The DON stated that to her knowledge, Resident #1 had never had a wander guard. The DON stated that the implementation of the wander guard device on 03/10 was the first one. The DON stated that if Resident #1 had a wander guard device it would be documented. The DON stated that you would have to have justification to put one on and take one off. The DON stated that usually the assessments are quarterly and would also use nursing judgement. The DON stated that if Resident #1 continues to score high that would call for a wander guard. The DON stated that LVN D was looking at safety first and this was why she had placed the wander guard on him prior to completing the assessment. The DON stated that the wander guard would not have stopped him from leaving. The DON stated that she had observed LVN D place the wander guard on Resident #1 and he was not resistant to the placement. The DON stated that she had felt that the placement of the wander guard was an emergency. The DON stated that at that moment she was just thinking safety first. The DON stated that she did tell LVN D that she did have to get the assessment done and she did not place Resident #1 on 1:1. The DON stated that frequent rounding was done on Resident #1. The DON did not look at his assessments or look at progress notes and did not review care plan. The DON stated that she thinks that this could have been prevented. The DON stated that they could have acted quicker. The DON stated that they could have implemented interventions such as 1:1 at the time of the first attempt. The DON stated that she is not familiar with the policy for incident and accidents, but the purpose is to prevent harm The DON stated that someone could get hurt if the policy is not followed. The DON stated that they could get into trouble for not having proper paperwork and consents. The DON stated that she was not aware that Resident #1 had a wander guard prior to the one placed on 03/10. The DON stated that she was not aware of the assessment outcome scores but she was aware that the wander guard was placed prior to the assessment. The DON stated that she thought that LVN D had called the family prior to the placement of the wander guard. The DON stated that the system to monitor incident/accident prevention was that they educate staff through in-services. The DON stated that she had not had any specific training at the facility but had nursing experience to know that you have to prevent incident and accidents. The DON stated that she expects incidents/accidents to be prevented by following the policy. The DON stated that all staff are responsible and there was no reason increased supervision was not implemented. The DON stated that stated that she is familiar of the policy for placing a wander guard. Stated that assessing the resident's first and obtaining the consent and making sure that the resident is safe with the restraint, make sure to document, speak to family, and make sure have the proper monitoring system in place. , stated that the purpose of a consent specifically for restraints is to ensure safety for the residents, to ensure that family is aware of the restraint, and to protect themselves as the facility. The DON stated that the negative outcome of not obtaining a consent for a restraint puts the facility at risk of getting into trouble because if it is not signed or documented it did not happen. The DON stated she was not aware that a consent was not obtained. Stated once again she will have to quit assuming and follow up as a DON. Stated she will start doing that and she will own her mistakes. The DON stated that she was aware that the nurse placed Resident #1's wander guard and did the assessment afterwards. The DON stated that she talked to the LVN about that and at that moment she felt it was an emergency to just put that one and I agree with her that she needed to place that on him and do visual assessment and put that in the computer. She saw the risk that he was and needed to do that. The DON stated that the system to monitor restraints is that they have the little device to check the wander guards and when it is activated they check with the doors to make sure that they work. Stated that these are checked every shift. The DON stated that she had been trained on restraints. The DON stated staff had been trained on restraints as well. The DON stated that she can verify

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility provided policy, dated September 2022, titled, Identifying Involuntary Seclusion and Unauthorized Restraint, stated: Policy Statement: As a part of the abuse prevention strategy, volunteers, employees, and contractors, hired by this facility are expected to be able to identify involuntary seclusion and or unauthorized restraint of residents. Policy Interpretation and Implementation: 4. Behavioral issues that arise among residents are managed according to strategies documented in the care plan and approved by the interdisciplinary team. Unauthorized Physical Restraints: 1. Restraints are free from the use of any physical restraints not required to treat their medical condition. 2. Physical restraint is defined as any manual method, physical, or mechanical device, equipment, or material that meets all of the following criteria. a. Is attached or adjacent to a resident's body. b. Cannot be removed easily by the resident (in the same manner as it was applied by the staff). 4. Sometimes the use of restraints is not intentional, but this does not absolve the staff of the responsibility to recognize and report the unauthorized use of restraints. Examples of physical restraints (intentional or unintentional) include: g. applying leg or arm restraints, hand mitts, soft ties, or vests that a resident cannot remove. 6. Risk of falling is not considered a medical symptom or self-injurious behavior that warrants the use of restraints. 9. Obtaining a resident's or representative's permission to use a restraint when the restraint is unnecessary is prohibited. 10. The following examples demonstrate situations where restraints are used for staff convenience or discipline, and are therefore unauthorized: a. Staff are too busy to monitor the resident, and their workload includes too many residents to provide monitoring. b. The resident does not exercise good judgment, including forgetting about his/her physical limitations in standing, walking, or using the bathroom alone and will not wait for staff assistance. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43150 Based on observation, interview and record review, the facility failed to develop a comprehensive care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs, as well as describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 3 of 3 residents (Resident #1, Resident #2, and Resident #3) reviewed for care plans in that: The facility failed to care plan for wander guards for Resident #1, Resident #2, and Resident #3. This deficient practice could place residents in the facility at risk of not being provided with the necessary care or services and not having personalized or individualized plans developed to address specific needs or concerns. Findings included: Resident #1: Record Review of Resident #1's face sheet dated 03/20/25 revealed a [AGE] year-old male with an original admitted [DATE] and a readmitted [DATE] with the following diagnoses: bacterial pneumonia (a serious lung infection caused by bacteria), metabolic encephalopathy (an acute condition of global cerebral dysfunction in the absence of primary structural disease), type 2 diabetes mellitus, hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid hormone), high blood pressure, hyperlipidemia (a condition in which there are high levels of fat particles in the blood), dementia, abnormalities of gait and mobility, lack of coordination, repeated falls, muscle weakness, acute kidney failure, psychotic disorder with hallucinations. Record review of Resident #1's Annual MDS (Minimum Data Set) assessment dated [DATE] revealed: He had a BIMS (Brief Interview for Mental Status) listed as 3, he had long and short-term memory impairment with severely impaired cognitive skills for daily decision making. Record review of Resident #1's Care Plan, dated 01/10/2025, revealed that Resident #1 was not care planned for wander guard. Review of Resident #1's Care Plan updated 8/13/24 revealed: Showed to be (dependent on staff etc.) for meeting emotional, intellectual, physical, and social needs r/t Cognitive deficits, Immobility. Resident #2: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #2's face sheet dated 03/20/25 revealed a [AGE] year-old female with an original admitted [DATE] and a readmitted [DATE] with the following diagnoses: seizures, intellectual disability, Microcephaly (a condition in which a baby's head is significantly smaller than expected often due to abnormal brain), scoliosis, osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bones wear down, depression, hyperlipidemia (a condition in which there are high levels of fat particles in the blood). Record review of Resident #2's Annual MDS (Minimum Data Set) assessment dated [DATE] revealed: He had a BIMS (Brief Interview for Mental Status) listed as 3, he had long and short-term memory impairment with severely impaired cognitive skills for daily decision making. Record review of Resident #2's Care Plan, dated 01/10/2025, revealed that Resident #2 was not care planned for wander guard. Resident #3: Record Review of Resident #3's face sheet dated 03/20/25 revealed a [AGE] year-old male with an admitted [DATE] with the following diagnoses: dementia, chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), acute kidney disease (a condition in which the kidneys suddenly cannot filter waste from the blood), urinary incontinence, high blood pressure, acid reflux, osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bones wear down). Record review of Resident #3's Quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed: He had a BIMS (Brief Interview for Mental Status) listed as 3, he had long and short-term memory impairment with severely impaired cognitive skills for daily decision making. Record review of Resident #3's Care Plan, dated 01/10/2025, revealed that Resident #3 was not care planned for wander guard. During an interview with ADON on 03/21/2025 at 11:17 AM, ADON stated that she was not familiar with the care plan policy. She stated that the purpose of the care plan is to obtain care of the patient. ADON stated to ensure that they are providing that care, know the patient if a patient like to use certain things, and for preferences. ADON stated that if it is not care planned the staff do not know about the patient or what to do. ADON stated that the negative potential outcome is that the facility may not meet the needs of the patient. ADON stated that she was unaware that there were missing wander guard care plans. ADON stated that the system to monitor care plans is that the facility monitors care plans quarterly and MDS and nursing are usually to collaborate. ADON stated that they do chart reviews periodically. ADON stated that she had not been trained on care plans. ADON stated that she expects staff to have the components they need according to policy. ADON stated that it is the responsibility of the MDS, Nursing staff are responsible in following them. ADON stated that the MDS coordinator actually completes them (care plans) because they may not have been done. ADON stated that the MDS coordinator last day was 2/28/25. ADON stated that they did hire a new MDS Coordinator, and they are working on care plans now. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/21/2025 at 12:00 PM and continued on 03/24/2025 at 6:17 PM, The Administrator stated that she had been in the facility since November 2024 and if Resident #1 had a wander guard it would have been documented. The Administrator stated that if Resident #1 were placed on 1:1, it would have been documented and an order for the increased supervision. The Administrator stated that they would have completed an assessment first before placing the wander guard. The Administrator stated that they would also have to have an order to remove a wander guard. The Administrator stating that with Resident #1 eloping successfully, after he had already attempted, could have been prevented. The Administrator stated that Resident #1 had showed signs of wanting to leave and the facility failed to place him on 1:1 supervision. The Administrator stated, I was told that they completed the assessment first and then called for a wander guard. The Administrator stated that it can be considered a restraint. The Administrator stated that the assessment will tell you if the Resident needed a wander guard. The Administrator stated that the guard will not stop the resident from getting out of the door, but it is an intervention. The Administrator stated that there is not a reason the assessment is done after the placement. The Administrator stated that she had not had anything on a 24-hour report for Resident #1. The Administrator stated that the facility system to monitor incident and accident prevention is review risk management daily and take the information from morning meetings and address as they are reported. The Administrator stated she is familiar with the policy for care planning for wander guard. The Administrator stated that she expectations in regard to care plans is that she expects for it to be accurate and up to date and it should be tailored to each resident. The Administrator stated that it is the responsibility of the IDT to make sure care plans are completed, It's not just one person, its all of us. The Administrator stated that stated that there is no good excuse for the care plans not being completed. The Administrator stated that she thinks that it goes back to the time that she did not have and MDS but not a good excuse or a specific reason. The Administrator stated that she was not aware that the resident's identified did not have their wander guards care planned until it was brought to her attention by the other Surveyor. The Administrator stated that a care plan is the guidelines of how they provide care for that specific need for the resident. The Administrator stated that the negative potential outcome of not care planning triggered items is not providing proper care for that specific resident to the best of their ability. The Administrator stated that mostly nursing uses the care plans. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/21/2025 at 12:22 PM, The DON stated that the facility failed to prevent incident and accident allowing Resident #1 to get out. The DON stated, I was in my office and was told that he was at the door. The DON stated that the incident prompted the wander guard situation. The DON stated that to her knowledge, Resident #1 had never had a wander guard. The DON stated that the implementation of the wander guard device on 03/10 was the first one. The DON stated that if Resident #1 had a wander guard device it would be documented. The DON stated that you have to have justification to put one on and take one off. The DON stated that usually the assessments are quarterly and also use nursing judgement. The DON stated that LVN D was looking at safety first and this was why she placed the wander guard on him prior to completing the assessment. The DON stated that she observed LVN D place the wander guard on Resident #1 and he was not resistant to the placement. The DON stated that she had felt that the placement of the wander guard was an emergency. The DON stated that if a resident had a wander guard, it should be care planned. The DON stated that a care plan provides details of what is going on with the resident and how to take care of them. The DON stated it is an overall story about the resident and needs. The DON stated that the negative potential outcome of not care planning triggered items is that if it is not care planned or documented then it could turn into not providing what is needed for them or meeting the resident's needs. The DON stated that she was not aware of the wander guard and behaviors were not care planned, until recently when she went in there and noticed that it was not care planned. The DON stated that when she noticed was on Friday 3/21/25. The DON stated that she assumed that it was done due to these residents being in the facility for so long. The DON stated that the person before her did not have it completed. The DON stated that when she looked it was not done, so she went in at that time and completed it. The DON stated that in regard to the facility system to monitor care plans is that she assumes that people know what needs to be done. The DON stated that she plans to go through each and every care plan to see what had or had not been taken care of. She stated that previously with old MDS, she would pull a 24-hour report and baseline and then DON would care plan it. The DON stated that they are in the process of re-training another person and communication also had played a role in the lack of care planning. She stated they will do risk meetings weekly with MDS and keep up to date with care plans. The DON stated that she had minimal training on care plans. She stated that her last MDS coordinator and her Corporate Nurse had given her training, but it was not much at all. The DON stated that therapy, activities, nursing, dietary, social worker, all use care plans. The DON stated that care plans are a summary of resident care and everything that they have going on from behaviors, needs, preferences. The DON stated if someone prefers to be eating in the dining by themselves that would be care planned. Record review of facility provided policy, dated March 2022, titled, Care Plans-Baseline stated: Policy Statement: A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within-forty-eight hours of admission. Policy Interpretation and Implementation: 1. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including but not limited to the following: a. Initial goals based on admission orders and discussion with the resident representative. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Physician orders. c. dietary orders. d. Therapy services. e. social services. f. PASARR recommendation if applicable 2. The baseline care plan is used until the staff can conduct a comprehensive assessment and develop an interdisciplinary person-centered comprehensive care plan, no later than 21 days after admission. The baseline care plan is updated as needed to meet the needs until the comprehensive care plan is developed. 3. A comprehensive care plan may be used in place of the baseline care plan providing the comprehensive care plan is developed within 48 hours of the resident's admission and meets the requirements of a comprehensive assessment at 483.21 4. The resident and/or representative are provided a written summary of the baseline care plan that includes, but is not limited to the following: a. The stated goals of the resident. c. any services and treatments to be administered by the facility and personnel acting on behalf of the facility. d. any updated information based on the details of the comprehensive care plan, as necessary.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 43150 Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 3 residents (Resident #1) reviewed for accidents, hazards, supervision. The facility failed to ensure Resident #1 received supervision and assistive devices to prevent accidents. Resident #1 was exit seeking and was able to elope and had fallen in the parking lot by the street. Staff were not aware of Resident #1's elopement and was found by Occupational Therapist that was off the clock. An Immediate Jeopardy (IJ) was identified on 03/21/25 at 3:32 PM. The IJ template was provided to the facility on [DATE] at 3:32 PM. While the IJ was removed on 03/22/25 at 5:36 PM; however, the facility remained out of compliance at No actual harm, with the potential for more than minimal harm with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures could place residents at risk for injuries due to not receiving the appropriate level of supervision. Findings included: Record Review of Resident #1's face sheet dated 03/20/25 revealed a [AGE] year-old male with an original admitted [DATE] and a readmitted [DATE] with the following diagnoses: bacterial pneumonia (a serious lung infection caused by bacteria), metabolic encephalopathy (an acute condition of global cerebral dysfunction in the absence of primary structural disease), type 2 diabetes mellitus, hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid hormone), high blood pressure, hyperlipidemia (a condition in which there are high levels of fat particles in the blood), dementia, abnormalities of gait and mobility, lack of coordination, repeated falls, muscle weakness, acute kidney failure, psychotic disorder with hallucinations. Record review of Resident #1's Annual MDS (Minimum Data Set) assessment dated [DATE] revealed: He had a BIMS (Brief Interview for Mental Status) listed as 3, he had long and short-term memory impairment with severely impaired cognitive skills for daily decision making. He felt tired or had little energy listed as 2-6 days. He was listed as using a manual wheelchair. He needed partial/moderate assistance to go from sitting to standing. Record review of Resident #1's Care Plan, dated 01/10/25, revealed that Resident #1 was not care planned for wander guard. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's Care Plan updated 8/13/24 revealed: Showed to be (dependent on staff etc.) for meeting emotional, intellectual, physical, and social needs r/t Cognitive deficits, Immobility. Record review of Resident #1's TAR for month of March 2025, revealed: Resident #1 was placed on 1:1 observations from 03/12/2025-3/21/2025, but no wander guard was listed on TAR. Record review of Resident #1's progress note dated 03/10/2025 at 2:59 PM, stated: 1300 Resident was at front door trying to get out of building. Wander guard applied to right wrist. Resident continues wandering throughout the building. Family called and notified. Recored review of Resident #1's progress note dated 03/10/2025 at 3:30 PM, stated: New order obtained from NP to place patient on one on one due to exit seeking behaviors. Record review of Resident #1's Head to Toe Skin Assessment, dated 03/13/2025 at 6:32 PM, stated: right and left forearm and right elbow. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/20/25 at 11:23 AM, Occupational Therapist A stated that she had seen Resident #1 outside around 3 pm. Occupational Therapist A stated that she had parked on the opposite end of the building, had made a left turn on the road, and then had seen someone standing with a walker in the parking lot. Occupational Therapist A stated that she had seen Resident #1 out of her peripheral vision. The Occupational Therapist A stated that he did not look like a visitor. The Occupational Therapist A stated that as she was parked, she had noticed Resident #1 had lost his balance and had seen him fall. The Occupational Therapist A stated that she had ran into the building and yelled out to Occupational Therapist B to assist. The Occupational Therapist A stated that she had ran to Resident #1 because he was in the street but barely on the side of the street. The Occupational Therapist B and Occupational Therapist A went to help Resident #1 up and at that point Physical Therapist came out with Resident #1's wheelchair. The Occupational Therapist A and Physical Therapist helped Resident #1 into the wheelchair and back into the building. The Occupational Therapist A stated that once they were back into the building, she wrote a statement. The Occupational Therapist A stated that she was off of the clock when this incident occurred. The Occupational Therapist A stated that her and the Physical Therapist C helped Resident #1, and she left after writing the statement. The Occupational Therapist A stated that she had not worked with Resident #1. The Occupational Therapist A stated that this was the second time that she had caught him. The Occupational Therapist A stated that the first time was around lunch, and she was on her way back from lunch. The Occupational Therapist A stated that Resident #1 was right at the door (outside of it, he just needed to let the door go). The Occupational Therapist A stated that Resident #1 did not have his walker at that time. The Occupational Therapist A stated that she had yelled for help from LVN D. The Occupational Therapist A stated that at that time they took him to get a wander guard. The Occupational Therapist A stated that was around noon and Resident #1 had not attempted to elope before that. The Occupational Therapist A stated that the first time that Resident #1 attempted to elope, he was not coherent, but he did make a comment saying something about needing a locker. The Occupational Therapist A stated that Resident #1 did not have a wander guard the first time he attempted to leave but on the second attempt, noticed a wander guard on Resident #1 because when Occupational Therapist A and Physical Therapist C brought Resident #1 back inside the wander guard went off. The Occupational Therapist A stated that she was not aware of any other elopements with residents. The Occupational Therapist A stated that she was not aware of any additional residents that exit seek. The Occupational Therapist A stated that she had not had any training regarding Resident #1's elopement. The Occupational Therapist A stated that she knows what it sounds like when the wander guard alerts and had been trained to go to the sound, each time the sound goes off and had been trained to go to the front door. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/20/25 at 11:35 AM, LVN D stated that the steps to do a wander guard depended on the resident if they are an elopement risk. LVN D stated that they would have to do a wandering assessment. LVN D stated that the wandering assessment will let you know if the resident is high risk. LVN D stated that the nurse initiates the risk assessment. LVN D stated that Resident #1 was wanting to get out the day he eloped and that he was trying to get to the door. LVN D stated that she put a wander guard on him when he tried to get out the first time that day. LVN D stated that she was unsure of the actual date. LVN D stated that she used PCC (point click care) for the assessment. LVN D stated that Resident #1 was in his wheelchair, and he was rolling around right after lunch. LVN D stated that Resident #1 was already agitated that day. LVN D stated that Resident #1 was saying that he was looking for his wife before lunch and after lunch he had stated that he needed to get to his car. LVN D stated that Resident #1 does not usually ambulate using his wheelchair on his own but on this day, he was independently rolling on his own. LVN D stated that Resident #1 was going to the front door, and she had redirected him and brought him to the desk. LVN D stated that she had told Resident #1 that the weather was bad to try and distract him. LVN D stated that she cannot remember if she offered to call his daughter that day to distract him. LVN D did the assessment on Resident #1 and put a wander guard on him. LVN D stated that she did the assessment on Resident #1, and it showed that he needed the wander guard. LVN D stated that she put the wander guard on Resident #1 first and she kept him with her the remainder of her shift. LVN D was not sure what time she had gotten off work. LVN D stated that she had kept eyes on him. LVN D stated that she reported to LVN E that Resident #1 had a wander guard. LVN D stated that she had put a wander guard on Resident #1's right wrist. LVN D stated that she had made the DON, Administrator, and ADON aware that she had placed the wander guard on Resident #1 around lunch time. LVN D stated that no one ever reported to her that Resident #1 had attempted to get out, but she did her assessment based on what she observed. LVN D stated that she did not observe Resident #1 get out of the facility but was told when she was leaving that he had gotten out. LVN D stated that Resident #1 was found outside and had fallen in the front. LVN D stated that she was not sure where at in the front Resident #1 was found. LVN D stated that she had last saw Resident #1 when she was giving report at 2:15 PM during shift change. LVN D stated that she did receive additional training after the incident (elopement drill) and elopement training. LVN D stated that she had been trained to announce it and everyone needs to start looking. LVN D stated that the Charge nurse needs to be the stationary person to report back to. LVN D stated that at that point someone needs to go outside and look. LVN D stated that you would also report to Administrator and DON and then after 15 minutes we need to call the police officers and call family. LVN D later explained that she tested the wander guard against a remote and again against the door prior to placing it on Resident #1. She stated staff member (CNA F) was present when she tested against the door. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/20/25 at 11:36 AM, the Physical Therapist C said she did not see Resident #1's elopement happen. She stated that she was in the front in the therapy area. The Physical Therapist C stated that she was unsure of the time and actual date but does know that it was daytime. The Physical Therapist C stated that earlier in the day before the elopement, the Occupational Therapist A was coming back in and saw Resident #1 standing at the door and she had brought him back inside. The Physical Therapist C stated that during the actual elopement, the Occupational Therapist A had thought that Resident #1 was a visitor and when she had realized that it was Resident #1, she had told nursing immediately what had happened. The Physical Therapist C stated that later that day she was in the therapy office and heard the door open and the Occupational Therapist A yell for the Occupational Therapist B. The Physical Therapist C stated that the Occupational Therapist A was leaving work and Resident #1 had gotten out of the door and off of the curb and had fallen. The Physical Therapist C stated she and the Occupation Therapist A had helped Resident #1 up and nursing had gotten him a wheelchair and brought him back into the building. The Physical Therapist C stated that the alarm did not go off on either the first or second time that Resident #1 eloped. The Physical Therapist C stated that when they hear the alarm, they move. The Physical Therapist C stated that one of them would have gone to check if the alarm had gone off; however, they did not hear it. The Physical Therapist C stated that they were trained to, hop up and get to it. The Physical Therapist C stated that Resident #1 had the wander guard on both times for the attempt and the actual elopement. The Physical Therapist C stated that the wander guard did not go off the first time, but it went off when Resident #1 was coming back through the door after he actually eloped. The Physical Therapist C stated that the wander guard alert system was working intermittently. The Physical Therapist C stated that nursing checks the wander guards, but she was unsure if it was the charge nurse or the DON. The Physical Therapist C stated that Resident #1 seemed unharmed when he actually eloped. The Physical Therapist C stated that when staff was bringing Resident #1 in from the actual elopement, he was telling the staff no that he wanted to go the other way. During an observation on 03/20/2025 at 1:03 PM, State surveyor tested the front door. Alarm sounded. Staff x3 came. During an interview on 03/20/2025 at 1:29 PM, CNA G stated that she was unsure of the exact date and time that Resident #1 was showing behaviors. CNA G stated that Resident #1 tried to get out prior to that actual elopement. CNA G stated that Resident #1 was yelling at staff, being physically abusive, and had bad language. CNA G stated that this was not Resident #1's normal behavior, but he was like this prior to his actual elopement. CNA G stated that she heard LVN D say that Resident #1 tried to leave. CNA G stated that they were watching him but did not do the 1:1. CNA G stated that the first time that Resident #1 tried to get out was when the wander guard was placed on him. CNA G stated that she had received a call while in the restroom and CNA H had stated that Resident #1 was outside. CNA G stated that she went out to help. CNA G stated that breaks are usually around 1:00 pm - 2:30 pm, so that would have to have been around the time Resident #1 was able to get out of the facility. CNA G stated that she was not too sure on the actual timing. CNA G stated that when she went outside, the resident, DON, and the Administrator, were coming inside. CNA G stated that the last time that she saw Resident #1 was approximately 10 minutes before the incident happened. CNA G stated that she did not hear the door alarm. CNA G stated that this had not happened with Resident #1 before, he had always talked about wanting to leave, but this was the first time that he eloped. During an observation on 03/20/2025 at 3:22 PM, Resident #1 observed the wander guard on left arm. He looked at it. Did not say what it was for. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675329	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2025
NAME OF PROVIDER OR SUPPLIER Levelland Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 210 West Ave Levelland, TX 79336	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation on 03/20/2025 at 4:37 PM-4:45 PM, tested the wander guard at the door near the room where the investigator was and the door down the right side (back) of the facility. The alert on the side and back of the facility have a faint sound. Staff did respond x3 to the side door and x 1 to the back door. During an interview on 03/20/2025 at 6:00 PM, Family Member #1 stated he/she was notified by Family Member #2 that Resident #1 had eloped. Family Member #1 stated that Resident #1 had a wander guard since being admitted . Family member #1 stated that Resident #1 does not get around very well and was not sure how Resident #1 was able to get outside with the wander guard and being as low as Resident #1 was. Family member stated that as a result of the incident they would be trying to place Resident #1 somewhere else. During an interview on 03/20/2025 at 6:05 PM, Physician stated that the facility may have notified his Nurse Practitioner about the elopement. Physician stated that he did not know if Resident #1 had a wander guard. Physician stated that Resident #1 had no elopement issues that he knew of. During an interview on 03/20/2025 at 6:13 PM, Family Member #2 stated she did not know the exact date, but she was told Resident #1 got out the front door. Family Member #2 did not say how far Resident #1 had gotten. Family Member #2 stated that it was told to her in the day that Resident #1 had managed to get out the front door. Family Member #2 stated that she was not sure if it was LVN D or LVN E that notified her. Family Member #2 stated that Resident #1 did not have his wander guard and had not had it for a while, it had been several weeks. Family member #2 stated that she did not know why they had taken the wander guard off. Family member stated that the facility did not notify them of the wander guard being taken off the first time or that they had placed one on Resident #1 the day he eloped from the facility. Family member #2 stated that after Resident #1 had fallen, the day that he eloped and had fallen outside, they had put the wander guard back on Resident #1. Family member #2 stated that it was observed that it was off but had never asked, and just assumed it was because Resident #1 quit wandering and never questioned it. Family member #2 stated that they had noticed the wander guard, but no one had mentioned putting it back on Resident #1. Family member #2 stated that she had seen Resident #1 the next day and noticed that they had placed the wander guard back on. Family member #2 stated that their concern was Resident #1 was at the back of the building. Family member #2 stated that Resident #1 had to walk down a long hallway to get out of the building. Family member #2 stated that no one had paid attention and noticed it, and this was concerning. Family member #2 stated that their parking lot was right by the street. Family member #2 stated prior to this incident they never had concern about Resident #1's care, until this. Family member #2 stated that they were fine with the placement of the wander guard but if they had been told that they were going to take it off they would have declined for the safety of Resident #1, it never was an issue. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/20/2025 at 6:35 PM, NP stated that she was notified on 03/10 that Resident #1 was trying to get out the front door and that he gotten out, right outside the door. NP stated it was her understanding that Resident #1 had not even gotten to the sidewalk. NP stated she was unaware that he gotten to the parking lot near the street. NP stated she received a text stating that they had put a wander guard on Resident #1 on 3/10. NP stated that she does not know if it was before or after he had actually eloped. NP stated her text that she had received stated I put a wander guard on Resident #1 because he was trying to get out of the building after lunch. The NP stated she had not had a text message that had showed that he had gotten out of the facility. NP stated she was unaware if Resident #1 had a wander guard prior to the placement on 03/10. NP stated she had never given an order for a wander guard to be taken off. NP stated they do notify her if they take it off and she has not had any notifications that one needed to be taken off of Resident #1. NP stated that they would have to had justification to take the wander guard off and put on. NP stated that she had a text on August 13 of 2024 that Resident #1 had tried to get out. NP stated that she did not know who texted because the number was not saved. NP stated that she had located the text says Resident #1 had gotten out. NP stated that she thought it was right outside of the door because she received a phone call letting her know they gotten Resident #1 back in. NP stated that when she calls about elopements and wander guard placements she will ask them what symptoms the resident had been having and what is the reason. NP stated that she had not received that information with Resident #1's case. NP stated that it was normal to have placed a wander guard after one attempt especially with Resident #1's case because the doors are unlocked from 7-8 PM. NP stated that it was case dependent in how they respond to elopements. NP stated it was situational. NP stated that in that facility it is almost impossible to actually monitor the front door and where the patient was going. NP stated that there was no way of watching that. NP stated that the wander guard was important because of the layout of the facility. NP stated that Resident #1 cannot walk fast, but fast enough. During an observation at 9:15 AM, The facility is located on [NAME] Avenue with posted speed limit of 55 mph. The cross street is 114 with a posted speed limit of 65 mph. There was an observation of the restaurant across the street that receives business during the day hours. The day that Resident #1 had eloped on 03/10/2025, it was 78 degrees with wind. During an observation and interview on 03/21/2025 at 9:38 AM, Maintenance Supervisor provided his checklist that he used to check the wander guard system. He stated he was required to check it weekly, but he does check the doors daily. He stated that he has not had any issues with the system. During an observation on 03/21/2025 at 10:05-10:08 AM: tested side door near the room where investigator was. Staff did not come down the hall until 10:08 AM x2. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/21/2025 at 10:17 AM, LVN D stated that she had spoken with Family member #2. LVN D stated that she had told Family Member #2 that she had placed a wander guard on Resident #1. LVN D stated that it was an emergent reason to put the wander guard on because Resident #1 was actively trying to get out. LVN D stated that she was 1:1 with him until got off that day, then the aides took over. LVN D stated that she does not remember if she documented it, and which aides took over. LVN D stated that no one took over her nursing duties while she was 1:1. LVN D stated it was after lunch, and she did not have anything at that moment that she needed to do. LVN D stated that Resident #1 had never had a wander guard. LVN D stated that this was the first time that Resident #1 had a wander guard. LVN D stated that you have to document when you place or remove a wander guard. LVN D stated that you have to notify the doctor to place the order. LVN D stated that she did not know if she had placed it in her note. LVN D stated that there was an order for the wander guard to be checked and changed. LVN D stated that she was there when Resident #1 tried to get out of the door. LVN D stated that Resident #1 was on the right side of the door, and he pushed it. LVN D stated that the door sounded, and she went over there and grabbed Resident #1. LVN D stated that she notified the DON, Administrator, and the ADON. LVN D stated Resident #1 should have been placed on 1:1. LVN D stated that was the protocol for at least 15-minute checks. LVN D stated that she was never instructed to place Resident #1 on 1:1. LVN D stated that she just watched Resident #1 closely based on her nursing experience. During an observation on 03/21/2025 at 10:37 AM, Resident #1 in his room, sleep in his recliner, wander guard on left arm. During an interview on 03/21/2025 at 10:38 AM, CNA I stated that Resident #1 did not have a wander guard before. CNA I stated that she was not sure how Resident #1 had not had his wander guard and why it was taken off. CNA I stated that Resident #1 will wander but he was not looking to get out and Resident #1 will say he needs to go home. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/21/2025 at 11:17 AM, ADON stated that Resident #1 had never had a wander guard before. ADON stated that the wander guard placed in March was the first one. ADON stated that the process for placing a wander guard was if the resident was showing signs an elopement assessment should be completed. ADON stated that the family should be notified of the behavior. ADON stated that the assessment would reveal a score and if the wander guard was needed. ADON stated that the family should be notified, and the documentation should reflect if they agree or disagree and then a consent should be signed if the family agree. ADON stated that if the family was not in agreement of the wander guard, then the resident can be placed on 24 hours observation and the family will try to identify a locked unit. ADON stated that it was not done in this case. ADON stated that she did not observe the placement of the wander guard on Resident #1. ADON stated that it was discussed as a group after Resident #1 had eloped. ADON stated that it had been discussed since Resident #1 was exit seeking and had not displayed that behavior before. ADON stated that labs were obtained with no findings. ADON stated that they discussed Resident #1 being placed on 1:1 and the Administrator had stated that they would need to find 1:1 staff for Resident #1. ADON stated that she did not know why the consent was not obtained or why the assessment was done afterwards. ADON stated that LVN D had reported the POA was called and given a verbal consent. ADON stated there was a call made to the NP. ADON stated she thought they had a consent. ADON stated that they had aids initially watching Resident #1. ADON stated that there was no observation log. ADON stated that the Administrator determined that it was an emergency and that was why the wander guard was placed on Resident #1. ADON stated that they were trained to document the placement of the wander guard and if it was taken off. ADON stated that they have to have justification to put a wander guard on and take it off. ADON stated that if it was not justified then the restraint is not justifiable. ADON stated that she thinks that this could have been prevented because when Resident #1 showed signs to want to leave the first time, the resident should have been monitored more frequently. ADON stated that Resident #1's room was right across from the nurse's station. ADON stated that Resident #1 was not quick and there was no reason someone did not see him. ADON stated that if they remove a wander guard an assessment should pop up in the system. ADON stated that if the assessment showed that Resident #1 no longer exhibited wandering then the nursing judgment would also be considered. ADON stated that the doctor should be called and get an order. ADON stated then the family should be called to remove the wander guard. ADON stated that she was familiar with the policy. ADON stated that the purpose of incident/accident prevention and supervision was safety of the resident. ADON stated that the incident could happen again if the policy was not followed. ADON stated that she did not see Resident #1 when he had eloped. ADON stated that she was told that Resident #1 was by the sidewalk onto the parking lot. ADON stated that the facility was by a busy road. ADON stated that Resident #1 does not have the ability to watch for traffic. ADON stated that she is aware that Resident #1 attempted to get out around lunch time. ADON stated that she was not aware that Resident #1 got out the second time. ADON stated that she was not aware that the wander guard was implemented prior to the assessment. ADON stated that she was not aware that Resident #1 had a wander guard prior to the one placed on 03/10/2025. ADON stated that she did not have any information regarding removal, and it should be care planned. ADON stated that she is not aware of Resident #1's scores from the past wandering assessments. ADON stated that the system to monitor incident/accident prevention and supervision would be to in-service staff and monitor to make sure nursing was following incident/accident policy, ensure that everything was documented, and make sure that there were follow ups and interventions for the resident. ADON stated that she had been trained on incident and accident prevention, supervision, and restraint policy. ADON stated that she would expect policy should be followed and incident and accidents should be prevented. ADON stated that everyone was responsible and there was no reason increased supervision did not occur on the first exit seeking attempt. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/21/2025 at 12:00 PM and continued on 03/24/2025 at 6:17 PM, the Administrator stated that she had been in the facility since November 2024 and that if Resident #1 had a wander guard it would have been documented. The Administrator stated that if Resident #1 were placed on 1:1, it would have been documented and an order for the increased supervision. The Administrator stated that they would have completed an assessment first before placing the wander guard. The Administrator stated that they would also have to have an order to remove a wander guard. The Administrator stated that with Resident #1 eloping successfully, after he had already attempted, could have been prevented. The Administrator stated that Resident #1 had showed signs of wanting to leave and the facility failed to place him on 1:1 supervision. The Administrator stated that she did provide an elopement in-service. The Administrator stated that, Everyone is responsible for keeping the resident safe. The Administrator stated, I was told that they had completed the assessment first and then had called for a wander guard. The Administrator stated that it could be considered a restraint. The Administrator stated that LVN D had documented that Resident #1 had went to the door. The Administrator stated that the assessment would tell you if the Resident needed a wander guard. The Administrator stated that the guard will not stop the resident from getting out of the door, but it is an intervention. The Administrator stated that there is not a reason the assessment is done after the placement. The Administrator stated that she had not had anything on a 24-hour report for Resident #1. The Administrator stated that she did an investigation. In her investigation she had not seen wander guard from any time before. The Administrator had not seen the high risk on all wandering assessments. She stated she did not look at the progress notes or assessments as a part of her investigation. The Administrator stated that she had not talked to the family since the elopement. She stated her team did tell her that they had notified the family. The Administrator stated that she did not follow up to check if the family had been notified. The Administrator stated that even in self-report all that was told to her was that the family was notified. The Administrator stated that she was unaware that the family had not been notified. The Administrator stated that the facility system to monitor incident and accident prevention was to review risk management daily and take the information from morning meetings and address as they are reported. The Administrator stated that she had been trained on incident and accident prevention. The Administrator stated they would have needed need to complete an assessment and then they would have to score a certain score, notify physician, notify family, sign the consent, before it could even be placed. It also would come with restrictions such as how often you would use it or when you remove it. The Administrator stated yes she was familiar with the policy for placing a wander guard. The Administrator stated that she was not aware that the assessment was completed after the restraint was placed on the resident, and once the IJ happened she learned of the situation. The Administrator stated that the system for monitoring for restraints was that she monitors when one is placed and would make sure DON had made her aware when one is placed, and she would follow up and have ADON monitor every week. The Administrator stated that she had been trained in restraints and her staff does complete orientation and annually as well. The Administrator stated that she had observed these residents (Resident #1, Resident #2, and Resident #3) with a wander guard on. The Administrator stated that her expectations in regard to restraint placement was that we are following our policy and that we are completing proper assessments before applying. The Administrator stated it was the responsibility of the charge nurses to apply restraints and complete assessments, and the responsibility of the ADON and DON to monitor. The Administrator stated that everyone was responsible for following the policy. The Administrator stated that there was no reason the assessment was completed after the placement of the wander guard as it relates to Resident #1, she thinks the nurse just wanted to be initiative-taking and was too initiative-taking. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/21/2025 at 12:22 PM, the DON stated that the facility failed to prevent incidents and accidents allowing Resident #1 to get out. The DON stated, I was in my office and was told that he was at the door. The DON stated that the incident prompted the wander guard situation. The DON stated that Resident #1 did not get out of the door, but he was at the door. The DON stated that she spoke with LVN D and