STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675352	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brentwood Place Three	3505 S Buckner Blvd Bldg 4 Dallas, TX 75227

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the physician was notified of changes for 1 of 5 residents (Resident #1) reviewed for elopement behaviors. The facility failed to inform the MD of Resident #1's elopement behaviors when requesting to discontinue his medical diagnosis of dementia.The failure could place residents at risk of not receiving the necessary care and treatment to meet their physical, mental, and psychosocial needs.Findings included: Record review of Resident #1's face sheet, dated 02/04/2026, reflected a [AGE] year-old male, admitted on [DATE] and discharged on 12/02/2025. Resident #1 diagnoses included cerebral infarction (blood clot forms in artery, disrupting blood flow to the brain, resulting in stroke) and osteoarthritis (protective cushion at ends of bones wear down, leading to stiffness and pain). Further record review of Resident #1's medical diagnoses revealed on 11/27/2025, the RNC had struck out the primary diagnosis dementia. The diagnosis did not appear on the face sheet. Record review of Resident #1's care plan, completed 11/07/2025, reflected:was at risk for elopement related to Elopement Evaluation risk score, initiated on 11/02/2025had impaired cognitive function/dementia or impaired thought processes r/t Dementia, initiated on 10/13/2025required psychotropic medications (Donepezil HCL) for diagnosis of (Dementia), initiated on 10/13/2025Record review of Resident #1's most recent care plan, revised 11/27/2025, reflected:had impaired cognitive function/dementia or impaired thought processes r/t Dementia, initiated on 10/13/2025required psychotropic medications (Donepezil HCL) for diagnosis of (Dementia), initiated on 10/13/2025was (high, moderate, low) risk for falls r/t Gait/balance problems, initiated 10/13/2025was a Potential Safety Risk When Leaving Facility Related to: Resident leaving facility without advance notice; history of similar behaviors in prior facilities. As evidence by: Independent exit, later self-admission to local hospital, initiated on 11/27/2025had psychiatric diagnosis (Schizophrenia/Depression/Anxiety) Related to: Chronic psychotic illness. As evidenced by: History of mental health conditions and preference to direct own care. Self-check in to local hospital, initiated on 11/27/2025 Exercising Autonomy / Independent Decision-Making Related to: Preference for self-directed choice, history of leaving facilities independently. As evidenced by: resident verbally stating he does not want to remain in facility; BIMS 13 demonstrating ability to make decisions; resident independently checking himself into local hospital, initiated on 11/27/2025The care plan revised 11/27/2025 did not reflect Resident #1's elopement attempt and actual elopements on 10/24/2025, 11/02/2025, and 11/27/2025. Record review of Resident #1's Elopement Risk Evaluations reflected: Date: 10/13/2025; Lock (Completed) Date: 10/13/2025 Resident #1 was a Moderate Risk, and able to make decisions regarding tasks of daily living, e.g. decisions are consistent and reasonable; and was able to ambulate or mobilize wheelchairs; Patient is cognitive impaired AND 1) ambulates or propels self. Patient may go outdoors on occasion but makes no attempt to leave grounds. Date: 11/02/2025; Lock (Completed) Date: 11/13/2025 Resident #1 was No Risk; and not able to make decisions (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: 675352	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2026
NAME OF PROVIDER OR SUPPLIER Brentwood Place Three		STREET ADDRESS, CITY, STATE, ZIP CODE 3505 S Buckner Blvd Bldg 4 Dallas, TX 75227	

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regarding tasks of daily living, e.g. decisions are consistent and reasonable; and unable to ambulate or mobilize wheelchairs. Additional information [Resident #1] is at risk for elopement related to Elopement Evaluation risk score.Date: 11/27/2025; Lock (Completed) Date: 02/04/2026 Resident #1 was No Risk; Resident #1 was able to make decisions regarding tasks of daily living, e.g. decisions are consistent and reasonable; and was able to ambulate or mobilize wheelchairs.Evaluations on 11/02/2025 and 11/27/2025 were not completed, staff only completed the questions in the No Risk section. Questions to evaluate Resident #1 as a Moderate Risk or Imminent Risk were triggered and but not completed for the electronic system to trigger the resident as moderate or imminent risk. There were discrepancies between the resident's elopement risk evaluations regarding his ability to make decisions and ambulate. Record review of Resident #1's progress notes reflected:Effective Date 10/24/2025: Security personnels at the gate called nurse to come for him because he wants to go home, ambulates with walker. Nurse went to the gate and spoke to him to come and express his concerns to the social worker as he proposed earlier. He agreed and came back with nurse to the building. Nurse accompanied him back in wheelchair with no problems. On q 2 hourly monitoring. Seemed co-operative with staff, calm, no aggressiveness. [sic]Effective Date 11/02/2025: Spoke with the resident's [Family Member #7 and Family Member #9] regarding the resident's exit seeking behavior; the couple stated that they are not surprised because every facility/psychiatric hospital he goes to he either checks himself out or he attempts to leave. The [Family Member #7] stated that his most recent stay was at a psychiatric hospital, he checked himself out, told the Police he wanted to go to [location], they put him on a bus, but he never made it there because he got off in [location] and here we are. The [Family Member #7] stated that he is unable to come and get him or find alternative placement because he doesn't know what is driving [Resident #1] to leave but he stated that he understand the liability the facility is faced with if he attempts to leave. [sic]Effective Date 11/02/2025: Resident sent to [psychiatric hospital]. Resident had two episodes of elopement from the facility. Resident showed signs of aggression and combativeness when asked why he wants to leave facility. Resident said, I want to leave this place, You people are holding me hostage, I want to leave. Resident was unable to articulate where he intends to go. The police were called to help control resident's behavior and outburst. Resident was finally sent to [psychiatric hospital]. The Doctor, Administrator, the don, and the Family Members where notified of the situation. [sic]Effective Date 11/14/2025, Created on 11/27/2025: Resident is a [AGE] year-old male with psychiatric history including schizophrenia, depression, anxiety, cognitive impairment, with a well-documented history of leaving prior facilities without notifying staff. Family members previously confirmed that the resident frequently leaves care settings independently and without authorization, noting this behavior has occurred at multiple facilities and psychiatric hospitals. Staff provided re-education on the facility's Leave of Absence (LOA) process, including expectation for notifying staff, safety procedures, required documentation, and the importance of arranging a responsible party for transport. Resident listened, verbalized understanding of the LOA procedure, and was informed that he may request an LOA appropriately if he chooses to leave temporarily. Resident declined to initiate an LOA at this time and continued to express general dissatisfaction with remaining in the facility but did not articulate a specific plan or destination. Staff attempted redirection, emotional support, and offered to contact family or the medical provider to discuss concerns. Resident declined all offers, stating only that he did not want [sic] tot stay. Resident remained cooperative and did not exhibit physical aggression, behavior escalation, or unsafe elopement attempts. Resident's [Family Member #7 and Family Member #9] were notified of the resident's statements. They reiterated consistent past behaviors of the resident leaving facilities on his (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	own, confirming that this pattern is typical for him. They verbalized understanding of the current situation and did not request additional intervention at this time. The physician/NP were notified. Resident remained under routine supervision with continued monitoring per care plan. [sic]Effective date 11/27/2025, Created on 12/02/2025: [Resident #1] is [AGE] year-old, with admitting diagnosis of Cerebral infarction, history of psychiatric diagnosis of schizophrenia and depression. Before admitting to facility resident has a history of deciding to leave facilities and hospitals due to own personal reasons. Resident is aware of his needs and able to make decisions regarding his care and safety. Resident decided to leave the facility 11/26 facility received information that resident independently checked himself into a local hospital. No injuries were reported. This action is consistent with the resident's baseline pattern of independently leaving prior facilities and making his own arrangements for care or evaluation. Resident's ability to navigate the community, arrive at a hospital, and seek medical attention on his own reflects preserved decision-making capacity and supports his cognitive ability to make autonomous choices regarding his whereabouts and medical. [sic] Record review on 02/05/2026 of Resident #1's psychiatry/therapy visits revealed Resident #1 was seen on 11/07/2025, 11/12/2025, and 11/18/2025. Resident #1 was referred for Depression, Tearfulness, Confusion, Elopement, Adjustment Disorder, High Risk Behavior. Resident #1's history of presenting illness included unreliable historian. does not remember attempting to elope, there was previous behavior for this and patient was placed on 1:1 for this. disoriented to situation. Resident #1 was noted to have been prescribed medications including Donepezil to treat for unspecified symptoms and signs involving cognitive function and awareness. Resident #1 was noted to endorse cognitive impairment symptoms of decreased concentration, forgetfulness, and difficulties with ADL.During an interview on 02/04/2026 at 5:16 P.M. with Family Member #7 and Family Member #9, they said Resident #1 had records of a dementia diagnosis, had shown signs of dementia, and could not make decisions for himself. Family Member #9 said Resident #1 had a medical bracelet on his wrist with his diagnoses of dementia and a stroke and Family Member #7 and Family Member #9's phone numbers. They said there were a couple times where Resident #1 left the facility between the bars on the gates and folded up his walker and put it through the gate; one time he had shown police where he did it. Family Member #9 said Resident #1 had called them before the facility did when he had left the facility. Family Member #9 was not sure how Resident #1 got out of the facility, and that another resident may have had a code; but they said by the third time that he took off it was like oh my gosh that's scary. We don't know that area and we would get a call from the hospital or police. They said 11/02/2025 was Resident #1's first time through the gate, and on 11/26/2025 they received a call from Resident #1 and was possibly transmitted to the hospital by police. They said they received a call from the facility on 11/27/2025 about Resident #1's room change. They said they understood the facility's frustration regarding Resident #1 leaving the facility. Family Member #9 mentioned it had been hard to find a new facility closer to them due to Resident #1's elopements.During an interview on 02/05/2026 at 10:46 A.M. with the RNC revealed she struck out the dementia diagnosis for Resident #1 because he had a high BIMS score and was not exhibiting signs of dementia based on nursing assessments. She said she spoke to the MD, and he said it was okay to discontinue the dementia diagnosis. She said she had done a record review for Resident #1 because he had left the building but stated I don't know if I would say he eloped. She then stated she specifically reviewed Resident #1's records on 11/27/2025 because it was a random review. She then said she did record reviews for residents when an event happened, and residents went to the hospital. During an interview on 02/05/2026 at 11:19 A.M. with the ADM revealed the facility had conducted a Resident behavior and attempting elopement in-services with 47 signatures and (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	post-tests that were completed regarding Resident #1's elopement on 11/26/2025. He said he did the in-services because Resident #1 left the building, but he did not report it to the state because it was not an elopement due to Resident #1 having a high BIMS score. He stated RN F's notes were not accurate on 11/02/2025 and there were no elopements and Resident #1 was not an elopement risk because he had a high BIMS score, he could make decisions, and he did not have dementia.During an interview on 02/05/2026 at 11:35 A.M. with Resident #1's MD, he stated Resident #1's diagnosis of dementia was discontinued on 11/27/2025 after he was informed by the facility that Resident #1's BIMS score was 13. The MD indicated the facility contacted him and he approved the diagnosis to be discontinued based on the BIMS score. He said he was not aware of Resident #1's exit seeking behaviors or elopement, and there was no documentation regarding Resident #1's exit seeking behaviors in his or his NP's notes. The MD said he did see Resident #1 was on medication for dementia. He said he did not know if Resident #1 was safe to leave the facility or ambulate independently. Interviews on 02/05/2026 and 02/06/2026 with RN E, RN G, LVN H, LVN I, RN J, LVN K, CNA L, all reported they had received in-service training over abuse and neglect and elopements and a post-test questionnaire regarding exit-seeking/elopement/wandering. In the event of an elopement, a code pink alert would be issued and they would notify the proper individuals including the DON, ADM, charge nurse, and physician. Staff reported they monitor residents and were aware of exit-seeking behaviors, including attempt to leave the facility, pushing on the doors, and statements of wanting to leave the facility, and report these behaviors to the ADM, DON, charge nurse and physician. During an interview on 02/06/2026 at 12:53 P.M. with the DON revealed staff had been in-serviced over elopements, exit seeking behaviors, and staff expectations, including notifying the physician. She indicated resident diagnoses and conditions will be discussed during Thursday (IDT) meetings with the NP present and communication with the physician who was present at least weekly. The DON said she received training from the RNC on elopement assessments, follow-up on interventions and care plan review, and she will notify the physician for all elopement related events. During an interview on 02/06/2026 at 2:05 P.M. with the ADM revealed all staff had received in-service training on the facility's policy and procedure for exit-seeking and elopement potential, prevention, notification, and management of actual elopements. He said in the event of an elopement, he, the DON, or charge nurse would notify the physician promptly. The ADM said when the doctor called, it should be documented. Record review of the facility's Wandering and Elopement policy, dated 08/2020, reflected: Purpose To enhance the safety of residents of the Facility.Policy The Facility will identify residents at risk for elopement and minimize any possible injury as a result of elopement.ProcedureI. The Licensed Nurse, in collaboration with the Interdisciplinary Team (IDT), will assess residents upon admission, readmission, quarterly, and upon identification of significant change in condition to determine their risk of wander/elopement.II. The resident's risk for elopement and preventative interventions will be documented in the resident's medical record, and will be reviewed and re-evaluated by the IDT upon admission, readmission, quarterly, and upon change in condition.VII. Response to Resident ElopementA. The Facility Staff member who finds that a resident is missing will alert Facility Staff.B. The Charge Nurse will call CODE PINK and organize a search. Facility Staff will search areas of the Facility, including common areas, bathrooms, showers, outside areas, etc.C. If the resident cannot be located, the Charge Nurse will notify:i. Administrator/designeeii. Director of Nursing Services/designee iii. Attending Physician iv. Responsible Partyv. Regional leadership of Clinical and Operations vi. Senior VP Of Operationvii. Senior VP of Clinical.VIII. Return of a ResidentA. When an individual who departed without following proper procedures returns to the Facility, the Director of Nursing Services or Licensed Nurse should:i. Examine the (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident for any possible injuries;ii. Notify the Attending Physician; and iii. Notify the resident's responsible party . Record review of the facility's Medical Record Content policy, dated 06/2020, reflected: PurposeTo ensure adequate and accurate documentation of care provided to each resident while at theFacility. ProcedureThe Facility will maintain a medical record for each resident admitted to the Facility that will containsufficient information to identify the resident, support the diagnosis, justify the medical necessity fortreatment, and facilitate continuity of care among health care providers. ProcedureI. The medical record will be accurate, timely and complete and may include the following content: .CC. Notification to Physician - Documentation and notification to the physician promptly of the following:i. admission of a resident;ii. Change of condition;iii. Unusual occurrences involving the resident;iv. Significant change in weight;v. Side effects or reaction to medication/treatment;vi. Any error in administration of medication;vii. The Facility's inability to obtain or administer, on a prompt and timely basis drugs, equipment, supplies, or service as prescribed under conditions which present a risk to the health, safety or security of the resident; andviii. Attempts to notify the physician will be noted, including the time, method of communication, the name of the person acknowledging contact, if any. If the Attending Physician is not readily available, emergency care will be provided.'

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure alleged violations of neglect were immediately reported to the State Agency within 24 hours for 1 of 5 (Resident #1) reviewed for elopement reporting. The facility failed to report Resident #1's subsequent and actual elopements from the facility on 11/02/2025 and 11/26/2025.This failure could place residents at risk of neglect and lack of oversight by the State Agency.Findings included:Record review of Resident #1's face sheet, dated 02/04/2026, reflected a [AGE] year-old male, admitted on [DATE] and discharged on 12/02/2025. Resident #1 diagnoses included cerebral infarction (blood clot forms in artery, disrupting blood flow to the brain, resulting in stroke) and osteoarthritis (protective cushion at ends of bones wear down, leading to stiffness and pain). Further record review of Resident #1's medical diagnoses revealed on 11/27/2025, the RNC had struck out the primary diagnosis dementia. The diagnosis did not appear on the face sheet. Record review of Resident #1's care plan, completed 11/07/2025, reflected:was at risk for elopement related to Elopement Evaluation risk score, initiated on 11/02/2025had impaired cognitive function/dementia or impaired thought processes r/t Dementia, initiated on 10/13/2025required psychotropic medications (Donepezil HCL) for diagnosis of (Dementia), initiated on 10/13/2025Record review of Resident #1's most recent care plan, revised 11/27/2025, reflected:had impaired cognitive function/dementia or impaired thought processes r/t Dementia, initiated on 10/13/2025required psychotropic medications (Donepezil HCL) for diagnosis of (Dementia), initiated on 10/13/2025was (high, moderate, low) risk for falls r/t Gait/balance problems, initiated 10/13/2025was a Potential Safety Risk When Leaving Facility Related to: Resident leaving facility without advance notice; history of similar behaviors in prior facilities. As evidence by: Independent exit, later self-admission to local hospital, initiated on 11/27/2025had psychiatric diagnosis (Schizophrenia/Depression/Anxiety) Related to: Chronic psychotic illness. As evidenced by: History of mental health conditions and preference to direct own care. Self-check in to local hospital, initiated on 11/27/2025 Exercising Autonomy / Independent Decision-Making Related to: Preference for self-directed choice, history of leaving facilities independently. As evidenced by: resident verbally stating he does not want to remain in facility; BIMS 13 demonstrating ability to make decisions; resident independently checking himself into local hospital, initiated on 11/27/2025The care plan revised 11/27/2025 did not reflect Resident #1's elopement attempt and actual elopements on 10/24/2025, 11/02/2025, and 11/27/2025. Record review of Resident #1's Elopement Risk Evaluations reflected: Date: 10/13/2025; Lock (Completed) Date: 10/13/2025 Resident #1 was a Moderate Risk, and able to make decisions regarding tasks of daily living, e.g. decisions are consistent and reasonable; and was able to ambulate or mobilize wheelchairs; Patient is cognitive impaired AND 1) ambulates or propels self. Patient may go outdoors on occasion but makes no attempt to leave grounds. Date: 11/02/2025; Lock (Completed) Date: 11/13/2025 Resident #1 was No Risk; and not able to make decisions regarding tasks of daily living, e.g. decisions are consistent and reasonable; and unable to ambulate or mobilize wheelchairs. Additional information [Resident #1] is at risk for elopement related to Elopement Evaluation risk score.Date: 11/27/2025; Lock (Completed) Date: 02/04/2026 Resident #1 was No Risk; Resident #1 was able to make decisions regarding tasks of daily living, e.g. decisions are consistent and reasonable; and was able to ambulate or mobilize wheelchairs.Evaluations on 11/02/2025 and 11/27/2025 were not completed, staff only completed the questions in the No Risk section. Questions to evaluate Resident #1 as a Moderate Risk or Imminent Risk were triggered and but not completed for the electronic system to trigger the resident as moderate or imminent risk. There were discrepancies between the resident's elopement risk evaluations (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regarding his ability to make decisions and ambulate. Record review of Resident #1's progress notes reflected:Effective Date 10/24/2025: Security personnels at the gate called nurse to come for him because he wants to go home, ambulates with walker. Nurse went to the gate and spoke to him to come and express his concerns to the social worker as he proposed earlier. He agreed and came back with nurse to the building. Nurse accompanied him back in wheelchair with no problems. On q 2 hourly monitoring. Seemed co-operative with staff, calm, no aggressiveness. [sic]Effective Date 11/02/2025: Spoke with the resident's [Family Member #7 and Family Member #9] regarding the resident's exit seeking behavior; the couple stated that they are not surprised because every facility/psychiatric hospital he goes to he either checks himself out or he attempts to leave. The [Family Member #7] stated that his most recent stay was at a psychiatric hospital, he checked himself out, told the Police he wanted to go to [location], they put him on a bus, but he never made it there because he got off in [location] and here we are. The [Family Member #7] stated that he is unable to come and get him or find alternative placement because he doesn't know what is driving [Resident #1] to leave but he stated that he understand the liability the facility is faced with if he attempts to leave. [sic]Effective Date 11/02/2025: Resident sent to [psychiatric hospital]. Resident had two episodes of elopement from the facility. Resident showed signs of aggression and combativeness when asked why he wants to leave facility. Resident said, I want to leave this place, You people are holding me hostage, I want to leave. Resident was unable to articulate where he intends to go. The police were called to help control resident's behavior and outburst. Resident was finally sent to [psychiatric hospital]. The Doctor, Administrator, the don, and the Family Members where notified of the situation. [sic]Effective Date 11/14/2025, Created on 11/27/2025: Resident is a [AGE] year-old male with psychiatric history including schizophrenia, depression, anxiety, cognitive impairment, with a well-documented history of leaving prior facilities without notifying staff. Family members previously confirmed that the resident frequently leaves care settings independently and without authorization, noting this behavior has occurred at multiple facilities and psychiatric hospitals. Staff provided re-education on the facility's Leave of Absence (LOA) process, including expectation for notifying staff, safety procedures, required documentation, and the importance of arranging a responsible party for transport. Resident listened, verbalized understanding of the LOA procedure, and was informed that he may request an LOA appropriately if he chooses to leave temporarily. Resident declined to initiate an LOA at this time and continued to express general dissatisfaction with remaining in the facility but did not articulate a specific plan or destination. Staff attempted redirection, emotional support, and offered to contact family or the medical provider to discuss concerns. Resident declined all offers, stating only that he did not want [sic] tot stay. Resident remained cooperative and did not exhibit physical aggression, behavior escalation, or unsafe elopement attempts. Resident's [Family Member #7 and Family Member #9] were notified of the resident's statements. They reiterated consistent past behaviors of the resident leaving facilities on his own, confirming that this pattern is typical for him. They verbalized understanding of the current situation and did not request additional intervention at this time. The physician/NP were notified. Resident remained under routine supervision with continued monitoring per care plan. [sic]Effective date 11/27/2025, Created on 12/02/2025: [Resident #1] is [AGE] year-old, with admitting diagnosis of Cerebral infarction, history of psychiatric diagnosis of schizophrenia and depression. Before admitting to facility resident has a history of deciding to leave facilities and hospitals due to own personal reasons. Resident is aware of his needs and able to make decisions regarding his care and safety. Resident decided to leave the facility 11/26 facility received information that resident independently checked himself into a local hospital. No injuries (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were reported. This action is consistent with the resident's baseline pattern of independently leaving prior facilities and making his own arrangements for care or evaluation. Resident's ability to navigate the community, arrive at a hospital, and seek medical attention on his own reflects preserved decision-making capacity and supports his cognitive ability to make autonomous choices regarding his whereabouts and medical. [sic] Record review on 02/05/2026 of Resident #1's psychiatry/therapy visits revealed Resident #1 was seen on 11/07/2025, 11/12/2025, and 11/18/2025. Resident #1 was referred for Depression, Tearfulness, Confusion, Elopement, Adjustment Disorder, High Risk Behavior. Resident #1's history of presenting illness included unreliable historian. does not remember attempting to elope, there was previous behavior for this and patient was placed on 1:1 for this. disoriented to situation. Resident #1 was noted to have been prescribed medications including Donepezil to treat for unspecified symptoms and signs involving cognitive function and awareness. Resident #1 was noted to endorse cognitive impairment symptoms of decreased concentration, forgetfulness, and difficulties with ADLs.During an interview on 02/04/2026 at 2:30 P.M. with RN E, she said she remembered Resident #1, and she remembered she had to get him from the security gate one time, but he did not go out the gate that day. She recalled when he left the faciity on [DATE] and said nobody knew what time he left but knew he was not there. RN E said she came in for her shift the next day and he came back from the hospital. She recalled she had done one-on-one monitoring with Resident #1 before 11/26/2025 and indicated he was not safe to be out of the facility by himself. RN E said elopements were reportable to the State, and nurses did not report to the State, but the ADM was responsible for reporting to the State.During an interview on 02/04/2026 at 5:16 P.M. with Family Member #7 and Family Member #9, they said Resident #1 had records of a dementia diagnosis, had shown signs of dementia, and could not make decisions for himself. Family Member #9 said Resident #1 had a medical bracelet on his wrist with his diagnoses of dementia and a stroke and Family Member #7 and Family Member #9's phone numbers. They said there were a couple times where Resident #1 left the facility between the bars on the gates and folded up his walker and put it through the gate; one time he had shown police where he did it. Family Member #9 said Resident #1 had called them before the facility did when he had left the facility. Family Member #9 was not sure how Resident #1 got out of the facility, and that another resident may have had a code; but they said by the third time that he took off it was like oh my gosh that's scary. We don't know that area and we would get a call from the hospital or police. They said 11/02/2025 was Resident #1's first time through the gate, and on 11/26/2025 they received a call from Resident #1 and was possibly transmitted to the hospital by police. They said they received a call from the facility on 11/27/2025 about Resident #1's room change. They said they understood the facility's frustration regarding Resident #1 leaving the facility. Family Member #9 mentioned it had been hard to find a new facility closer to them due to Resident #1's elopements.During an interview on 02/05/2026 at 10:46 A.M. with the RNC revealed she struck out the dementia diagnosis for Resident #1 because he had a high BIMS score and was not exhibiting signs of dementia based on nursing assessments. She said she spoke to the MD, and he said it was okay to discontinue the dementia diagnosis. She said she had done a record review for Resident #1 because he had left the building but stated I don't know if I would say he eloped. She then stated she specifically reviewed Resident #1's records on 11/27/2025 because it was a random review. She then said she did record reviews for residents when an event happened, and residents went to the hospital. During an interview on 02/05/2026 at 11:35 A.M. with Resident #1's MD, he stated Resident #1's diagnosis of dementia was discontinued on 11/27/2025 after he was informed by the facility that Resident #1's BIMS score was 13. The MD indicated the facility contacted him and he approved the diagnosis to be discontinued based on the BIMS (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	score. He said he was not aware of Resident #1's exit seeking behaviors or elopement, and there was no documentation regarding Resident #1's exit seeking behaviors in his or his NP's notes. The MD said he did see Resident #1 was on medication for dementia. He said he did not know if Resident #1 was safe to leave the facility or ambulate independently.Attempted phone call interview on 02/05/2026 at 4:29 P.M. with RN F regarding progress notes on 11/02/2025 when Resident #1 was sent to the psych hospital. RN F did not return the state surveyor's phone call.During an interview on 02/05/2026 at 7:23 P.M. with the previous SW, she said she worked at the facility when Resident #1 was there. She said Resident #1 was fuzzy (confused) about how he was admitted to the facility, and Family Member #7 said his memory was not the best. She said Resident #1 was an elopement risk and he had used a walker; she further said he had dug under the fence of the facility and talked about leaving very often. The previous SW said she recalled when Resident #1 eloped on 11/26/2025. She said she did not know who told the ADM Resident #1 was not in the facility, but it was facility staff who told him. She said the ADM called her, and she then called around to the closest hospitals until she found Resident #1, and she contacted the family. During an interview on 02/06/2026 at 1:09 P.M. with the DON revealed the facility staff reported to her and the ADM if an incident occurred and expected them to report immediately. She indicated the ADM was responsible for making the decision to determine if an incident was reportable to the State because he was head of the facility. The DON stated reporting incidents to the State was important because it made sure (the facility) abided by regulations of the State, and for the safety of the residents. During an interview on 02/06/2026 at 2:40 P.M. with the ADM, he stated RN F's notes were not accurate on 11/02/2025 and there were no elopements and that Resident #1 was not an elopement risk because he had a high BIMS score, he could make decisions, and he did not have dementia. The ADM said he was responsible for reporting incidents to the State, if he was not available, the DON can report. He said it was important to report incidents to notify HHSC of what was going on in the facility and to make sure the facility was in compliance, but also not to just investigate but (HHSC) support of the facility when they need support and help. The ADM indicated abuse was reported to the State within 2 hours, and incidents (i.e. elopements) without injury were to be reported within 24 hours. He said staff were to report to him immediately, so he had time to ask questions and interview people. During an interview on 02/06/26 at 03:24 P.M. with RN J, she stated she reported any incidents to the Administrator, and they report to the State. If they did not report something to the State, the problem could just continue or even escalate.Record review of the facility's Abuse Prevention and Prohibition Program policy, dated 01/2025, reflected: PurposeTo ensure the Facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements. PolicyI. Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. The Facility has zero-tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property. II. The Facility is committed to protecting residents from abuse by anyone, including but not limited to Facility Staff, other residents, consultants, volunteers, staff from other agencies serving residents, Family Members, legal guardians, surrogates, sponsors, friends, and visitors. This policy statement also includes deprivation by any individual, including a caretaker, of goods, services or rights that are necessary for a resident to attain or maintain physical, mental, and psychosocial (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wellbeing. III. The Administrator is responsible for coordinating and implementing the Facility's abuse prevention policies, procedures, training programs, and systems. Procedure I. The Administrator may delegate coordination and implementation of components of the abuse prevention program to other staff within the Facility . V. IdentificationA. The Facility provides covered individuals with training to enable the identification of the following signs and symptoms of potential resident abuse and neglect:i. Physical Abuse.ii. Physical Neglect.iii. Possible Signs and Symptoms of Psychological Abuse or Neglect.VI. InvestigationA. The Facility promptly and thoroughly investigates reports of resident abuse, mistreatment, neglect, injuries of an unknown source, or criminal acts .B. If the Administrator receives a report of an incident or suspected incident of resident abuse, mistreatment, neglect, injuries of an unknown source or crime, the Administrator or designee, may appoint a member of the Facility's management team (the Investigator) to investigate the alleged incident.I. The Administrator will submit initial and follow-up written reports of the results of all abuse investigations and consequent actions to the appropriate agencies as outlined in Section IX below.IX. Reporting/ResponseA. Facility Staff are Mandatory Reportersi. Facility owners, operators, employees, managers, agents, and contractors are obligated by the Elder Justice Act and any state specific regulations to report known or suspected instances of abuse of elder or dependent adults.B. Administrator, or his/her designee, as Abuse Coordinator.C. All mandated reporters will report reasonable suspicion of a crime against a resident when it is objectively reasonable for a person to entertain a suspicion of conduct that appears to be financial abuse, physical abuse, neglect, abandonment, isolation, abduction, or other treatment resulting in physical harm or pain or mental suffering, deprivation of goods or services that are necessary to avoid physical harm or mental suffering.D. The Facility will report allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property, or other incidents that qualify as a crime.i. Immediately, but no later than 2 hours after forming the suspicion - if the alleged violation involves abuse or results in serious bodily injury to the state survey agency, adult protective services, law enforcement, and the Ombudsman (if applicable per state regulation).ii. No later than 24 hours after forming the suspicion - if the alleged violation (e.g., misappropriation of property, neglect) does not involve abuse and does not result in serious bodily injury to the state survey agency, adult protective services, law enforcement, and the Ombudsman (if applicable per state regulation).iii. Reporting requirements are based on real (clock) time, not business hours.iv. The Administrator will provide the state survey agency, law enforcement and the Ombudsman (if applicable per state regulation) with a copy of the investigative report within 5 days of the incident .v. If a resident experienced or alleges an instance of abuse at a location other than the Facility, the Administrator, or his/her designee, shall report the instance of abuse to Adult Protective Services agency and the local law enforcement agency.vi. The resident's attending physician and responsible party, if applicable, will also be notified of the of the allegation and outcome of the investigation.vii. Failure to file a report within the required time frames may result in disciplinary action, up to and including termination.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives to meet the resident's medical, nursing, mental and psychosocial needs for 1 of 5 residents (Resident #1) reviewed for care plans. The facility failed to develop and implement the care plan for Resident #1's risk of elopement since his initial elopement attempt on 10/24/2025 and subsequent elopement attempt and actual elopement on 11/02/2025 and 11/26/2025.The facility failed to revise the care plan for Resident #1 to reflect his medical diagnosis of dementia.This failure could place residents at risk for not receiving proper care and services. Findings included: Record review of Resident #1's face sheet, dated 02/04/2026, reflected a [AGE] year-old male, admitted on [DATE] and discharged on 12/02/2025. Resident #1 diagnoses included cerebral infarction (blood clot forms in artery, disrupting blood flow to the brain, resulting in stroke) and osteoarthritis (protective cushion at ends of bones wear down, leading to stiffness and pain). Further record review of Resident #1's medical diagnoses revealed on 11/27/2025, the RNC had struck out the primary diagnosis dementia. The diagnosis did not appear on the face sheet. Record review of Resident #1's admission MDS, dated [DATE], revealed Resident #1 had a BIMS score of 13, indicating intact cognitive function and ability to recall information immediately. Active diagnoses included Progressive Neurological Conditions, i.e. stroke (interruption of blood flow to brain) and non-Alzheimer's dementia (can be caused by a stroke and result in cognitive decline, behavioral change, etc.). The MDS assessment revealed Resident #1 did not exhibit wandering behaviors.Record review Resident #1's BIMS assessments reflected: 10/13/2025 - Moderately impaired 1010/13/2025 - Cognitively intact 1310/24/2025 - Cognitively intact 1512/2/2025 - Cognitively intact 13 Record review of Resident #1's care plan, completed 11/07/2025, reflected:was at risk for elopement related to Elopement Evaluation risk score, initiated on 11/02/2025had impaired cognitive function/dementia or impaired thought processes r/t Dementia, initiated on 10/13/2025required psychotropic medications (Donepezil HCL) for diagnosis of (Dementia), initiated on 10/13/2025Record review of Resident #1's most recent care plan, revised 11/27/2025, reflected:had impaired cognitive function/dementia or impaired thought processes r/t Dementia, initiated on 10/13/2025required psychotropic medications (Donepezil HCL) for diagnosis of (Dementia), initiated on 10/13/2025was a Potential Safety Risk When Leaving Facility Related to: Resident leaving facility without advance notice; history of similar behaviors in prior facilities. As evidence by: Independent exit, later self-admission to local hospital, initiated on 11/27/2025had psychiatric diagnosis (Schizophrenia/Depression/Anxiety) Related to: Chronic psychotic illness. As evidenced by: History of mental health conditions and preference to direct own care. Self-check in to local hospital, initiated on 11/27/2025 Exercising Autonomy / Independent Decision-Making Related to: Preference for self-directed choice, history of leaving facilities independently. As evidenced by: resident verbally stating he does not want to remain in facility; BIMS 13 demonstrating ability to make decisions; resident independently checking himself into local hospital, initiated on 11/27/2025The care plan revised 11/27/2025 did not reflect Resident #1's elopement attempt and actual elopements on 10/24/2025, 11/02/2025, and 11/27/2025. Record review of Resident #1's Elopement Risk Evaluations reflected: Date: 10/13/2025; Lock (Completed) Date: 10/13/2025 Resident #1 was a Moderate Risk, and able to make decisions regarding tasks of daily living, e.g. decisions are consistent and reasonable; and was able to ambulate or mobilize wheelchairs; Patient is cognitive impaired AND 1) ambulates or propels self. Patient may go outdoors on occasion but makes no attempt to leave grounds. Date: 11/02/2025; Lock (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Completed) Date: 11/13/2025 Resident #1 was No Risk; and not able to make decisions regarding tasks of daily living, e.g. decisions are consistent and reasonable; and unable to ambulate or mobilize wheelchairs. Additional information [Resident #1] is at risk for elopement related to Elopement Evaluation risk score.Date: 11/27/2025; Lock (Completed) Date: 02/04/2026 Resident #1 was No Risk; Resident #1 was able to make decisions regarding tasks of daily living, e.g. decisions are consistent and reasonable; and was able to ambulate or mobilize wheelchairs.Evaluations on 11/02/2025 and 11/27/2025 were not completed, staff only completed the questions in the No Risk section. Questions to evaluate Resident #1 as a Moderate Risk or Imminent Risk were triggered and but not completed for the electronic system to trigger the resident as moderate or imminent risk. There were discrepancies between the resident's elopement risk evaluations regarding his ability to make decisions and ambulate. Record review of Resident #1's order summary, dated 02/04/2026 reflected:Donepezil HCL Oral Tablet 10 MG (Donepezil Hydrochloride) Give 1 tablet by mouth at bedtime for Dementia Donepezil 5mg qhs x 6wks then increase to 10mg po qhs. Start Date: 11/24/2025Donepezil HCL Oral Tablet 5 MG (Donepezil Hydrochloride) Give 1 tablet by mouth at bedtime for Dementia for 6 weeks. Start Date: 10/13/2025 End Date:11/24/2025 Record review of Resident #1's MAR reflected:10/13/2025-11/23/2025: Resident #1 was given Donepezil HCL Oral Tablet 5 MG everyday as ordered, except for 10/29/2025, 11/2/2025, and 11/23/2025 due to being hospitalized or other (instructed to see nurses note) during the time of the scheduled dose. 11/24/2025-12/02/2025: Resident #1 was given Donepezil HCL Oral Tablet 10 MG everyday as ordered, except on 11/24/2025 and 11/26/2025 due to being away from the facility during the time of the scheduled dose. Record review of Resident #1's progress notes reflected:Effective Date 10/24/2025: Security personnels at the gate called nurse to come for him because he wants to go home, ambulates with walker. Nurse went to the gate and spoke to him to come and express his concerns to the social worker as he proposed earlier. He agreed and came back with nurse to the building. Nurse accompanied him back in wheelchair with no problems. On q 2 hourly monitoring. Seemed co-operative with staff, calm, no aggressiveness. [sic]Effective Date 11/02/2025: Spoke with the resident's [Family Member #7 and Family Member #9] regarding the resident's exit seeking behavior; the couple stated that they are not surprised because every facility/psychiatric hospital he goes to he either checks himself out or he attempts to leave. The [Family Member #7] stated that his most recent stay was at a psychiatric hospital, he checked himself out, told the Police he wanted to go to [location], they put him on a bus, but he never made it there because he got off in [location] and here we are. The [Family Member #7] stated that he is unable to come and get him or find alternative placement because he doesn't know what is driving [Resident #1] to leave but he stated that he understand the liability the facility is faced with if he attempts to leave. [sic]Effective Date 11/02/2025: Resident sent to [psychiatric hospital]. Resident had two episodes of elopement from the facility. Resident showed signs of aggression and combativeness when asked why he wants to leave facility. Resident said, I want to leave this place, You people are holding me hostage, I want to leave. Resident was unable to articulate where he intends to go. The police were called to help control resident's behavior and outburst. Resident was finally sent to [psychiatric hospital]. The Doctor, Administrator, the don, and the Family Members where notified of the situation. [sic]Effective Date 11/14/2025, Created on 11/27/2025: Resident is a [AGE] year-old male with psychiatric history including schizophrenia, depression, anxiety, cognitive impairment, with a well-documented history of leaving prior facilities without notifying staff. Family Members previously confirmed that the resident frequently leaves care settings independently and without authorization, noting this behavior has occurred at multiple facilities and psychiatric hospitals .Effective date 11/27/2025, Created on 12/02/2025: [Resident #1] is [AGE] (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	year-old, with admitting diagnosis of Cerebral infarction, history of psychiatric diagnosis of schizophrenia and depression. Before admitting to facility resident has a history of deciding to leave facilities and hospitals due to own personal reasons. Resident is aware of his needs and able to make decisions regarding his care and safety. Resident decided to leave the facility 11/26 facility received information that resident independently checked himself into a local hospital. No injuries were reported. This action is consistent with the resident's baseline pattern of independently leaving prior facilities and making his own arrangements for care or evaluation. Resident's ability to navigate the community, arrive at a hospital, and seek medical attention on his own reflects preserved decision-making capacity and supports his cognitive ability to make autonomous choices regarding his whereabouts and medical. [sic]During an interview on 02/04/2026 at 2:30 P.M. with RN E, she said she remembered Resident #1, and she remembered she had to get him from the security gate one time, but he did not go out the gate that day. She recalled when he left the faciity on [DATE] and said nobody knew what time he left but knew he was not there. RN E said she came in for her shift the next day and he came back from the hospital. She recalled she had done one-on-one monitoring with Resident #1 before 11/26/2025 and indicated he was not safe to be out of the facility by himself. During an interview on 02/05/2026 at 10:46 A.M. with the RNC revealed she struck out the dementia diagnosis for Resident #1 because he had a high BIMS score and was not exhibiting signs of dementia based on nursing assessments. She said she spoke to the MD and he said it was okay to discontinue the dementia diagnosis. She said she was not aware of the PASRR the MD signed on 11/11/2025 stating Resident #1 had a primary diagnosis of dementia. The RNC said she did not document the conversation or justification for changing the medical records. She said she had done a record review for Resident #1 because he had left the building but stated I don't know if I would say he eloped. She then stated she specifically reviewed Resident #1's records on 11/27/2025 because it was a random review. She then said she did record review for residents when an event happened, and residents went to the hospital. RNC indicated she was not aware that Resident #1 was care planned for dementia and dementia medication. During an interview on 02/05/2026 at 11:35 A.M. with Resident #1's MD, he stated Resident #1's diagnosis of dementia was discontinued on 11/27/2025 after he was informed by the facility that Resident #1's BIMS score was 13. The MD indicated the facility contacted him and he approved the diagnosis to be discontinued based on the BIMS score. He said he was not aware of Resident #1's exit seeking behaviors or elopement, and there was no documentation regarding Resident #1's exit seeking behaviors in his or his NP's notes. The MD said he did see Resident #1 was on medication for dementia. He said he did not know if Resident #1 was safe to leave the facility or ambulate independently.During an interview on 02/06/2026 at 1:09 P.M. with the DON, she said admitting nurses were responsible for opening care plans (when a resident was admitted), and the managers (DON) and the MDS nurse will make changes or add to it. The DON said care plans were important because care plans show staff how to take care of residents; care plans that were not updated were a risk because staff could miss out on giving specific care or whatever was needed for that resident.During an interview on 02/06/2026 at 2:40 P.M. with the ADM revealed the MDS nurse, the DON, and ADONs were responsible for care plans and nurses could assist with care plans. He said care plans were important because they made sure staff were providing adequate and the right care for residents. The ADM indicated staff discuss changes in residents' care in morning meetings and if there were changes, staff made changes to residents' care plans. He said sometimes staff were late to making changes, but they catch up. The ADM stated the risk of not having an updated care plan depended on the situation, but care plans needed updated and that was why staff monitor every day. He indicated the facility had care plan conferences with families (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and the SW and constantly updated care plans. The ADM said they could not have a resident without an updated care plan, and it could be like a risk of not giving a resident medication. The ADM indicated he did not know why Resident #1's care plan was not updated, and he continued to be given medication for dementia. He said maybe something happened around that time (i.e. Thanksgiving); but it was not an excuse to not update it. During an interview on 02/06/2026 at 3:24 P.M. with RN J, she stated care plans were important because it's like your guide to care. It gives you something to follow when you are providing care. Record review of the facility's care planning policy, dated 10/24/2022, reflected: PurposeTo ensure that a comprehensive person-centered Care Plan is developed for each resident based on their individual assessed needs. PolicyI. The Facility's Interdisciplinary Team (IDT) will develop a Baseline and/or Comprehensive Care Plan for each resident in accordance with OBRA and MDS guidelines.II. The Care Plan serves as a course of action where the resident (resident's family and/or guardian or other legally authorized representative), resident's Attending Physician, and IDT work to help the resident move toward resident-specific goals that address the resident's medical, nursing, mental and psychosocial needs.III. A Licensed Nurse will initiate the Care Plan, and the plan will be finalized in accordance with OBRA/[sic]NDS guidelines and updated as indicated for change in condition, onset of new problems, resolution of current problems, and as deemed appropriate by clinical assessment and judgment on an ass needed bases. Procedure.VIII. A culturally competent and trauma-informed comprehensive person-centered Care Plan will be developed for each resident. The Care Plan will include measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs.A. In the event that the Comprehensive Care Plan identified a change in the resident's goals or functioning that was not identified in the Baseline Care Plan, these changes will be incorporated into an updated summary and provided to the resident and/or resident's representative.B. Changes may be made to the Comprehensive Care Plan on an ongoing basis for the duration of the resident's stay. These subsequent changes will not need to be reflected through updates to the Baseline Care Plan. IX. Each resident's Comprehensive Care Plan will describe the following:A. Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being;B. Any services that would be required, but are not provided due to the resident's exercise of rights, which includes the right to refuse treatment. X. The Comprehensive Care Plan must be completed within 7 days after completion of the Comprehensive admission Assessment, and must be periodically reviewed and revised by a team of qualified persons after each assessment, including the comprehensive and quarterly review assessments. XI. The Comprehensive Care Plan must be prepared by the IDT team. The IDT team includes the following individuals:A. The Attending Physician;B. The Resident Assessment Coordinator;C. The Licensed Nurse who has responsibility for the resident;D. The Dietary Supervisor and/or registered dietician;E. Social Service staff member responsible for the resident;F. The Activity Director;G. Therapists as applicable;H. Consultants (as appropriate);I. The Director of Nursing (as applicable);J. Certified Nursing Assistants and/or RNAs responsible for the resident's care;K. The resident and/or his/her family or legal representative;i. If the resident and his/her resident representative participation is determined not practicable for the development of the resident's care plan, an explanation should be included in the resident's medical record.L. Other individuals as appropriate or necessary.a. The resident has the to identify individuals or roles to be included in the care planning process. XI. Resident Rights - Care PlanningA. The resident has a right to be informed, in advance, of changes to the plan of care.B. The resident has the right to receive the services and/or items included in the plan of care.C. The resident has the right to see the care plan, including the right to sign after significant changes are made to the (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan of care. XII. IDT MeetingsA. The Facility will invite the resident, if capable, and their family to care planning meetings and use its best efforts to schedule care planning meetings at times convenient for the resident and family.i. When a resident does not have family, or if the resident/family requests it, the IDT will invite the Ombudsman to attend the care planning meeting. B. IDT meetings may be conducted via teleconference. XIII. The IDT will revise the Comprehensive Care Plan as needed at the following intervals:A. Per RAI schedules;B. As dictated by changes in the resident's condition;C. In preparation for discharge;D. To address changes in behavior and care; andE. Other times as appropriate or necessary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675352	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2026
NAME OF PROVIDER OR SUPPLIER Brentwood Place Three		STREET ADDRESS, CITY, STATE, ZIP CODE 3505 S Buckner Blvd Bldg 4 Dallas, TX 75227	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision for 1 of 5 residents (Resident #1) reviewed for elopement. The facility failed to ensure Resident #1 was adequately supervised when Resident #1 left the faciity on [DATE] and climbed through the fence and walked blocks away from the facility. Resident #1 contacted 911 and was transported to a nearby hospital. Resident #1 was located at a nearby hospital after the previous SW had called around to the closest hospital trying to find Resident #1. Staff did not know what time he left but were aware of his exit-seeking behavior and previous elopement attempt from the facility.An IJ was identified on 02/05/2026. The IJ template was provided to the ADM on 02/05/2026 at 11:29 A.M. While Resident #1 no longer resided at the facility, the facility remained out of compliance at a scope of isolated and severity of no actual harm with potential for more than minimal harm that was not immediate. The IJ was removed on 02/06/2026.This failure placed residents at serious risk of getting lost and sustaining injuries.Findings included:Record review of Resident #1's face sheet, dated 02/04/2026, reflected a [AGE] year-old male, admitted on [DATE] and discharged on 12/02/2025. Resident #1 diagnoses included cerebral infarction (blood clot forms in artery, disrupting blood flow to the brain, resulting in stroke) and osteoarthritis (protective cushion at ends of bones wear down, leading to stiffness and pain). Further record review of Resident #1's medical diagnoses revealed on 11/27/2025, the RNC had struck out the primary diagnosis dementia. The diagnosis did not appear on the face sheet. Record review of Resident #1's admission MDS, dated [DATE], revealed Resident #1 had a BIMS score of 13, indicating intact cognitive function and ability to recall information immediately. Active diagnoses included Progressive Neurological Conditions, i.e. stroke (interruption of blood flow to brain) and non-Alzheimer's dementia (can be caused by a stroke and result in cognitive decline, behavioral change, etc.). The MDS assessment revealed Resident #1 did not exhibit wandering behaviors.Record review of Resident #1's BIMS assessments reflected: 10/13/2025 - Moderately impaired 1010/13/2025 - Cognitively intact 1310/24/2025 - Cognitively intact 1512/2/2025 - Cognitively intact 13 Record review of Resident #1's Elopement Risk Evaluations reflected:Date: 10/13/2025; Lock (Completed) Date: 10/13/2025 Resident #1 was a Moderate Risk, and able to make decisions regarding tasks of daily living, e.g. decisions are consistent and reasonable; and was able to ambulate or mobilize wheelchairs; Patient is cognitive impaired AND 1) ambulates or propels self. Patient may go outdoors on occasion but makes no attempt to leave grounds. Date: 11/02/2025; Lock (Completed) Date: 11/13/2025 Resident #1 was No Risk; and not able to make decisions regarding tasks of daily living, e.g. decisions are consistent and reasonable; and unable to ambulate or mobilize wheelchairs. Additional information [Resident #1] is at risk for elopement related to Elopement Evaluation risk score.Date: 11/27/2025; Lock (Completed) Date: 02/04/2026 Resident #1 was No Risk; Resident #1 was able to make decisions regarding tasks of daily living, e.g. decisions are consistent and reasonable; and was able to ambulate or mobilize wheelchairs.Evaluations on 11/02/2025 and 11/27/2025 were not completed, staff only completed the questions in the No Risk section. Questions to evaluate Resident #1 as a Moderate Risk or Imminent Risk were triggered and but not completed for the electronic system to trigger the resident as moderate or imminent risk. There were discrepancies between the resident's elopement risk evaluations regarding his ability to make decisions and ambulate. Record review of Resident #1's care plan, completed 11/07/2025, reflected:was at risk for elopement related to Elopement Evaluation risk score, initiated on 11/02/2025had impaired cognitive function/dementia or impaired thought processes r/t Dementia, initiated on 10/13/2025required psychotropic medications (Donepezil HCL) (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	for diagnosis of (Dementia), initiated on 10/13/2025Record review of Resident #1's most recent care plan, revised 11/27/2025, reflected:had impaired cognitive function/dementia or impaired thought processes r/t Dementia, initiated on 10/13/2025required psychotropic medications (Donepezil HCL) for diagnosis of (Dementia), initiated on 10/13/2025was (high, moderate, low) risk for falls r/t Gait/balance problems, initiated 10/13/2025was a Potential Safety Risk When Leaving Facility Related to: Resident leaving facility without advance notice; history of similar behaviors in prior facilities. As evidence by: Independent exit, later self-admission to local hospital, initiated on 11/27/2025had psychiatric diagnosis (Schizophrenia/Depression/Anxiety) Related to: Chronic psychotic illness. As evidenced by: History of mental health conditions and preference to direct own care. Self-check in to local hospital, initiated on 11/27/2025 Exercising Autonomy / Independent Decision-Making Related to: Preference for self-directed choice, history of leaving facilities independently. As evidenced by: resident verbally stating he does not want to remain in facility; BIMS 13 demonstrating ability to make decisions; resident independently checking himself into local hospital, initiated on 11/27/2025The care plan revised 11/27/2025 did not reflect Resident #1's elopement attempt and actual elopements on 10/24/2025, 11/02/2025, and 11/27/2025. Record review of Resident #1's progress notes reflected:Effective Date 10/24/2025: Security personnels at the gate called nurse to come for him because he wants to go home, ambulates with walker. Nurse went to the gate and spoke to him to come and express his concerns to the social worker as he proposed earlier. He agreed and came back with nurse to the building. Nurse accompanied him back in wheelchair with no problems. On q 2 hourly monitoring. Seemed co-operative with staff, calm, no aggressiveness. [sic]Effective Date 11/02/2025: Spoke with the resident's [Family Member #7 and Family Member #9] regarding the resident's exit seeking behavior; the couple stated that they are not surprised because every facility/psychiatric hospital he goes to he either checks himself out or he attempts to leave. The [Family Member #7] stated that his most recent stay was at a psychiatric hospital, he checked himself out, told the Police he wanted to go to [location], they put him on a bus, but he never made it there because he got off in [location] and here we are. The [Family Member #7] stated that he is unable to come and get him or find alternative placement because he doesn't know what is driving [Resident #1] to leave but he stated that he understand the liability the facility is faced with if he attempts to leave. [sic]Effective Date 11/02/2025: Resident sent to [psychiatric hospital]. Resident had two episodes of elopement from the facility. Resident showed signs of aggression and combativeness when asked why he wants to leave facility. Resident said, I want to leave this place, You people are holding me hostage, I want to leave. Resident was unable to articulate where he intends to go. The police were called to help control resident's behavior and outburst. Resident was finally sent to [psychiatric hospital]. The Doctor, Administrator, the don, and the Family Members where notified of the situation. [sic]Effective Date 11/14/2025, Created on 11/27/2025: Resident is a [AGE] year-old male with psychiatric history including schizophrenia, depression, anxiety, cognitive impairment, with a well-documented history of leaving prior facilities without notifying staff. Family members previously confirmed that the resident frequently leaves care settings independently and without authorization, noting this behavior has occurred at multiple facilities and psychiatric hospitals. Staff provided re-education on the facility's Leave of Absence (LOA) process, including expectation for notifying staff, safety procedures, required documentation, and the importance of arranging a responsible party for transport. Resident listened, verbalized understanding of the LOA procedure, and was informed that he may request an LOA appropriately if he chooses to leave temporarily. Resident declined to initiate an LOA at this time and continued to express general dissatisfaction with remaining in the facility but did not articulate a (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	specific plan or destination. Staff attempted redirection, emotional support, and offered to contact family or the medical provider to discuss concerns. Resident declined all offers, stating only that he did not want [sic] tot stay. Resident remained cooperative and did not exhibit physical aggression, behavior escalation, or unsafe elopement attempts. Resident's [Family Member #7 and Family Member #9] were notified of the resident's statements. They reiterated consistent past behaviors of the resident leaving facilities on his own, confirming that this pattern is typical for him. They verbalized understanding of the current situation and did not request additional intervention at this time. The physician/NP were notified. Resident remained under routine supervision with continued monitoring per care plan. [sic]Effective date 11/27/2025, Created on 12/02/2025: [Resident #1] is [AGE] year-old, with admitting diagnosis of Cerebral infarction, history of psychiatric diagnosis of schizophrenia and depression. Before admitting to facility resident has a history of deciding to leave facilities and hospitals due to own personal reasons. Resident is aware of his needs and able to make decisions regarding his care and safety. Resident decided to leave the facility 11/26 facility received information that resident independently checked himself into a local hospital. No injuries were reported. This action is consistent with the resident's baseline pattern of independently leaving prior facilities and making his own arrangements for care or evaluation. Resident's ability to navigate the community, arrive at a hospital, and seek medical attention on his own reflects preserved decision-making capacity and supports his cognitive ability to make autonomous choices regarding his whereabouts and medical. [sic]Effective date 11/29/2025: Resident continue to be on one on one monitoring, resting quietly.Effective date 12/1/2025: Resident continue on one-on-one monitoring as ordered.Records did not show documentation of orders or discussion to change Resident #1's dementia diagnosis and details of elopements.Record review on 02/05/2026 of Resident #1's transfer form to discharge to the hospital, dated 11/02/2025, revealed Resident #1 was alert, disoriented, but cannot follow simple instructions, ambulates with assistive device, and requires assistance for ADLs. Resident #1 was noted to may attempt exit as an additional risk. Record review on the facility's Resident Out On Pass Log dated 10/26-12/01/2025 revealed Resident #1 had been signed out on 10/27 and 11/20 by Family Member #7. Resident #1 never signed out.Record review on 02/05/2026 of Resident #1's psychiatry/therapy visits revealed Resident #1 was seen on 11/07/2025, 11/12/2025, and 11/18/2025. Resident #1 was referred for Depression, Tearfulness, Confusion, Elopement, Adjustment Disorder, High Risk Behavior. Resident #1's history of presenting illness included unreliable historian. does not remember attempting to elope, there was previous behavior for this and patient was placed on 1:1 for this. disoriented to situation. Resident #1 was noted to have been prescribed medications including Donepezil to treat for unspecified symptoms and signs involving cognitive function and awareness. Resident #1 was noted to endorse cognitive impairment symptoms of decreased concentration, forgetfulness, and difficulties with ADLs.During an interview on 02/04/2026 at 11:00 A.M. with CNA B revealed she recalled Resident #1 and he was at facility for a short time. She said she could not recall the exact situation but indicated the resident had left the facility at one point. During an interview on 02/04/2026 at 11:36 A.M. with the Activities Director revealed she remembered Resident #1 well. She said she remembered hearing that Resident #1 tried to leave the facility, but she did not see it. She further stated, If I don't see it, it didn't happen. During an interview on 02/04/2026 at 11:51 A.M. with Resident #2 revealed he was Resident #1's roommate at one point and said Resident #1 constantly wanted to escape. Resident #2 recalled one time when Resident #1 tried to dig out under the fence at the facility but was stopped by facility staff. Resident #2 said Resident #1 walked slow and used a walker, and it wasn't like he was going to get away.During an interview on 02/04/2026 at 2:05 P.M. with (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	LVN D, she said she remembered Resident #1 but could not really recall him eloping. She said she had come back to work, and it was discussed, she said maybe the ADM or staffing coordinator called her, but she did not remember. She said she kept her eye on him 24/7 and he was very tricky because (staff) did not know what he was going to do the next minute, and it was a real issue with him. LVN D said he was on one-on-one observation at one time and that was the key (intervention). She said he was an elopement risk and indicated he showed signs including exit-seeking and verbalizing wanting to leave, and she had to redirect him. During an interview on 02/04/2026 at 2:30 P.M. with RN E, she said she remembered Resident #1, and she remembered she had to get him from the security gate one time, but he did not go out the gate that day. She said he once left and came back from the hospital but did not know if it was elopement because she did not know if someone picked him up. RN E discussed Resident #1 would watch staff movements and times (to find an opportunity to leave). She said nobody knew what time he left (on 11/26/2025), but knew he was not there. RN E said she came in for her shift the next day and he came back from the hospital. She recalled she had done one-on-one monitoring with Resident #1 before 11/26/2025 and indicated he was not safe to be out of the facility by himself. During an interview on 02/04/2026 at 5:16 P.M. with Family Member #7 and Family Member #9, they said Resident #1 had records of a dementia diagnosis, had shown signs of dementia, and could not make decisions for himself. Family Member #9 said Resident #1 had a medical bracelet on his wrist with his diagnoses of dementia and a stroke and Family Member #7 and Family Member #9's phone numbers. They said there were a couple times were Resident #1 left the facility between the bars on the gates and folded up his walker and put it through the gate; one time he had shown police where he did it. Family Member #9 said Resident #1 had called them before the facility did when he had left the facility. Family Member #9 was not sure how Resident #1 got out of the facility, and that another resident may have had a code; but they said by the third time that he took off it was like oh my gosh that's scary. We don't know that area and we would get a call from the hospital or police. They said 11/02/2025 was Resident #1's first time through the gate, and on 11/26/2025 they received a call from Resident #1, and he was possibly transmitted to the hospital by police. They said they received a call from the facility on 11/27/2025 about Resident #1's room change. They said they understood the facility's frustration regarding Resident #1 leaving the facility. Family Member #9 mentioned it had been hard to find a new facility closer to them due to Resident #1's elopement.During an interview on 02/05/2026 at 10:46 A.M. with the RNC revealed she struck out the dementia diagnosis for Resident #1 because he had a high BIMS score and was not exhibiting signs of dementia based on nursing assessments. She said she spoke to the MD, and he said it was okay to discontinue the dementia diagnosis. She said she had done a record review for Resident #1 because he had left the building but stated I don't know if I would say he eloped. She then stated she specifically reviewed Resident #1's records on 11/27/2025 because it was a random review. She then said she did record reviews for residents when an event happened, and residents went to the hospital. During an interview on 02/05/2026 at 11:35 A.M. with Resident #1's MD, he stated Resident #1's diagnosis of dementia was discontinued on 11/27/2025 after he was informed by the facility that Resident #1's BIMS score was 13. The MD indicated the facility contacted him and he approved the diagnosis to be discontinued based on the BIMS score. He said he was not aware of Resident #1's exit seeking behaviors or elopement, and there was no documentation regarding Resident #1's exit seeking behaviors in his or his NP's notes. The MD said he did see Resident #1 was on medication for dementia. He said he did not know if Resident #1 was safe to leave the facility or ambulate independently.Attempted phone call interview on 02/05/2026 at 4:29 P.M. with RN F regarding progress notes on 11/02/2025 when Resident #1 was sent to the psych (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	hospital. RN F did not return the state surveyor's phone call.During an interview on 02/05/2026 at 7:23 P.M. with the previous SW, she said she worked at the facility when Resident #1 was there. She said Resident #1 was fuzzy (confused) about how he admitted to the facility and Family Member #7 said his memory was not the best. She said Resident #1 was an elopement risk and he had used a walker; she further said he had dug under the fence of the facility and talked about leaving very often. The previous SW said she recalled when Resident #1 eloped on 11/26/2025. She said she did not know who told the ADM Resident #1 was not in the facility, but it was facility staff because she had called around to the closest hospitals until she found Resident #1 and she contacted the family. During an interview on 02/06/2026 at 9:31 A.M. with the receptionist revealed she worked 11/26/2025 when Resident #1 eloped, and she had let him in and out of the facility multiple times that day and he did not sign out. She said she had never seen Resident #1 elope or attempt to. The receptionist stated there was an elopement binder with a list of residents who can and cannot go outside, and who she cannot open the door for. She indicated she kept an eye on residents who could go outside but had to call a nurse if the resident tried to leave. She said if residents were to leave the facility and go pass the gates, they must have a pass and their nurses were notified they went out on pass.During an interview on 02/05/2026 at 11:19 A.M. with the ADM revealed the facility had conducted a Resident behavior and attempting elopement in-services with 47 signatures and post-tests that were completed regarding Resident #1's elopement on 11/26/2025. He said he did the in-services because Resident #1 left the building, but he did not report it to the state because it was not an elopement due to Resident #1 having a high BIMS score. He stated RN F's notes were not accurate on 11/02/2025 and there were no elopements and Resident #1 was not an elopement risk because he had a high BIMS score, he could make decisions, and he did not have dementia. The ADM was notified on 02/05/2026 at 11:19 A.M. that an IJ was identified, the IJ template was provided at 11:29 A.M. and a Plan of Removal was requested. The facility's Plan of Removal was accepted on 02/06/2026 at 12:30 P.M. and reflected the following to Remove the Immediate Jeopardy: Initial Investigation Post Event:The resident's routine included visits to the front porch and gazebo area. On the day of the incident, staff documented that the resident went to the gazebo as usual and returned to the facility on three separate occasions. The receptionist provided door access assistance during these routine visits.Post-Incident Review:Following the incident, the facility conducted a comprehensive review of the exit pathway. The investigation revealed that the resident exited through the front entrance during his routine outdoor visits (approximately 4-5pm timeframe) and subsequently left the campus grounds by navigating the perimeter fencing [NAME]. Upon discovery that the resident had left campus grounds, staff initiated the facility's emergency response protocol. The resident called 911 and requested to be returned to [the facility] upon contact with authorities but was rather transferred to the emergency room.Identify residents who could be affectedAll residents have the potential to be affected. Identify responsible staff/ what action takenResident has been discharged to Assisted Living Facility. No longer in the facility.Other residents with elopement were assessed. One resident with a elopement assessment was identified. No changes in care plan identified.Nursing staff received re-education by the DON on the facility policy and procedure for exit seeking and elopement potential. Employees reeducated on elopement prevention, notification, and management of actual elopementsReeducation includes posttests for confirmation of training.Physician will be notified of elopement potential for timely management of clinical condition.Facility will seek alternate management for residents with active elopement seeking. Alternate placement may include but not be limited to secured unit, or other placement of choice by the resident / responsible party by the IDT (Social worker).Audit of all resident's elopement (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	assessment completed, and care planned by licensed staff on February 5, 2026.Current Security Infrastructure: Delayed egress doors on primary exits Door alarm systems with central monitoring Secured perimeter gates with access control Residents leaving facility will be reviewed by the interdisciplinary team for safety and ability to leave the facility safely. The Gate keepers personnels has been reeducated by the Area Administrator on ensuring that residents leaving the gate have a pass from the facility, and to notify the facility of any concerns related to residents leaving the gate without clearance. Identification of residents deemed at Risk for Elopement with High BIMS Resident who has high BIMs and are at risk for elopement will be referred to the psychiatrist / provide for additional recommendation to validate elopement potential. Residents deemed to be at risk for elopement despite High BIMS by the provider or psychiatrist will reviewed by the IDT for alternate placement. IDT will review provider's recommendation for further care plan.BIMS was one component of our comprehensive elopement risk assessment, not the sole determinant. Our facility utilizes the PointClickCare comprehensive elopement risk assessment tool which evaluates multiple clinical factors.BIMS score is one data point within this comprehensive tool, not the sole or primary determinant. Our clinical decision-making integrates:??????1.????BIMS results (standardized cognitive screening per MDS 3.0 requirements)??????2.????Comprehensive elopement risk assessment tool results??????3.????Direct observation of functional cognitive abilities??????4.????Behavioral patterns documented during facility stay??????5.????Interdisciplinary team clinical judgmentFacility will continue to utilize elopement system, but take into account resident's underlying diagnosis with physician's input in resident's care. Dementia diagnosis was integrated into our comprehensive assessment and care planning.Walker use was assessed as part of functional mobility evaluation. How often will assessment take placeResident will be assessed upon admission, readmission, change in condition, new behavior of exit seeking and as clinically determined by the facility.Residents' assessment will be reviewed for changes in assessment that may require additional follow-up. Identification of elopement by nursing staff:Resident will be assessed by licensed nurses upon admission, admission, change in condition, new behavior of exit seeking and as clinically determined by the facility.Residents identified with changes in initial elopement assessment will be reviewed in clinical meeting. IDT will determine need for further follow-up. In-Service conductedIn-service was conducted by Director of Nursing or Administrator on February 5, 2026. The in-service is focused on elopement potentials, resident safety. The details of the in-service include: Assessment of residents with elopement potentialMonitoring of behavioral symptoms Visualizing each resident during rounds Rounding every 2 hours Conduct a midnight headcount census by charge nurse Report Missing resident's immediately to the supervisor and/or charge nurse, administrator, director of nursing, physician, responsible party Immediately search the facility; rooms, common areas, perimeter of the building, [sic]10mile radius of the facility The in-service was attended by licensed caregivers which include Registered Nurse, Licensed Vocational Nurse, Certified Nursing Assistants, Certified Medication Aide, and Licensed Therapists which include Physical Therapist, Occupational Therapist and Speech therapist. For staff who are unavailable for training on this date, they will not be allowed to return to work until training is complete. Inservice will include non-licensed staff on elopement prevention. This in-service was initiated on February 5, 2026. The Regional Nurse will reeducate the Director of Nursing on elopement assessment, follow-up on interventions, and care plan review. The Area administrator will reeducate the facility's administrator on elopement assessment, and /or reporting criteria to the Health and Human Services Commission (HHSC) according to reporting requirements. Implementation of ChangesThe changes were started by the Director of Nursing / Administrator. The changes were implemented effective on February 5, 2026 and will be (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	ongoing until all staff are re-educated. The Director of Nursing will ensure competency through verbalization of understanding by staff and completion of returned questionnaire. Physician Notification and Documentation Requirement The Director of Nursing or Assistant Director of Nursing will oversee the notification of physician for elopement related event. Documentation of elopement potential (actual or potential) will be documented in medical record. Care plan will be reviewed to meet the resident's clinical status. Monitoring The Administrator/Director of Nursing/Assistant Director of Nursing will be responsible for monitoring the implementation and effectiveness of in-service on February 5, 2026. The Director of Nursing or designee will complete audit tool for monitoring on Elopement Assessment, care plan, follow-up.Director of Nursing/Assistant Director of Nursing will conduct weekly audit of Elopement assessment x4 weeks, then bi-weekly x 2 weeks, then monthly and report any adverse findings during QAPIResidents will be monitored by staff every shift for any exit seeking behaviors. Any changes will be reported to the Director of Nursing, Administrator, Physician immediately for appropriate action.Areas of performance improvement identified during audits, or observations will be addressed upon identification. Involvement of Medical DirectorAn HOC QAPI regarding the incident was conducted on February 5, 2026, and the Plan of removal was reviewed and accepted by Medical Director Involvement of QAAn Ad Hoc QAPI meeting was held with the Medical Director, facility administrator, director of nursing, and social services director to review plan of removal on February 5, 2026. Who is responsible for implementation of process?The Director of Nursing will be responsible for implementation of New Process. The New Process/ system was started on February 5, 2026. Please accept this letter as our plan of removal for the determination of Immediate Jeopardy verbally issued on February 5, 2026. [sic] Monitoring the Plan of Removal on 02/05/2026 and 02/06/2026 included: During an interview on 02/05/2026 at 1:34 P.M. with DON revealed Resident #3 was the only current resident identified to be an elopement risk, and she was reassessed that day. Record review at this time of Resident #3's progress notes revealed she was reassessed on 02/05/2026 at 1:06 P.M. and was noted to remains at moderate risk for elopement but has no episodes of actively exit seeking.During an observation on 02/05/2026 at 3:05 P.M. of Resident #3, revealed she wandered the hallway and was confused, but did not exhibit exit seeking behaviors. No other residents demonstrated exit-seeking behaviors; front desk was monitored by receptionist, and the door required a code for exit. During an interview on 02/05/2026 at 5:03 P.M. with the incoming ADM revealed staff had been in-serviced and given the post-test questionnaire in person if they were working or via phone call if they were not in the facility; a mass text message was sent to all staff including the elopement training. He said staff who were in-serviced via phone call could not return to work until they signed the in-service and completed the post-test questionnaire. During an observation on 02/05/2026 5:25 P.M. revealed an elopement binder at nurse's station and front desk by front door, with picture of Resident #3 because she was an elopement risk. The state surveyor pushed the front door without the code entry, and an alarm was triggered and could be heard throughout the facility. Staff looked towards the exits and staff responded to enter the code for the door and allowed state surveyor to open the door. Interviews on 02/05/2026 and 02/06/2026 with RN E, RN G, LVN H, LVN I, RN J, LVN K, CNA L, CNA M, the BOM, staff coordinator, the hospitality aide, the housekeeper, and the receptionist all reported they had received in-service training over abuse and neglect and elopements and a post-test questionnaire regarding exit-seeking/elopement/wandering. Staff reported if a resident was suspected to be missing, they would look inside the building and then outside the building. In the event of an elopement, a code pink alert would be issued and they would notify the proper individuals including the DON, ADM, charge nurse, and physician. Staff reported all doors required codes to enter/exit the facility, and (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	codes were not given to residents. Staff reported they monitor residents and were aware of exit-seeking behaviors, including attempt to leave the facility, pushing on the doors, and statements of wanting to leave the facility, and report these behaviors to the ADM, DON, charge nurse and physician. Direct care staff (RNs, LVNs, CNAs, and hospitality aide) reported they did rounds on residents at least every 2 hours, monitor census, and interventions for exit-seeking behaviors included one-on-one monitoring and redirection. GK N and GK O revealed the gate stayed closed at all times and was opened by a garage clicker. They reported they had received training regarding residents must have a pass for them to open the gate. They reported if a resident did not have a pass and tried to leave, they would try to redirect the resident and notify the facility for assistance. During an interview on 02/06/2026 at 12:53 P.M. with the DON, she stated residents that were actively elopement seeking would have alternate management (placement) sought; hospitalization would be done by her, and other type of placement would be done by the SW. She said the elopement risk assessments were done every 3 months and as needed (i.e. resident exit-seeking). The DON said this was discussed in the daily IDT meetings; additionally, residents with a high BIMS scores and were elopement risks would be discussed the meetings and referred to psychiatric services for recommendations and interventions would be added to resident care plans by her or the ADON. The DON said she reviewed all residents' elopement risk assessments for accuracy and there was no change. Residents' diagnosis and physician/provider input will be discussed every Thursday meeting with the NP present and communication with the physician who was present at least weekly. Dementia diagnosis and functional mobility evaluations would be considered as part of the review with the IDT in making decisions. The DON said residents that want to leave the facility will be reviewed

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure medical records were complete, accurately documented, readily accessible, and systematically organized for 1 of 5 residents (Resident #1) reviewed for medical record accuracy. The facility failed to ensure there was not a discrepancy in Resident #1's dementia diagnosis that was discontinued, while his records (care plan, orders, psychiatric visits, and MAR) indicated Resident #1 was actively treatment for dementia.The facility failed to document the verbal conversation with Resident #1's MD regarding the discontinuation of dementia diagnosis.The facility failed to accurately and consistently complete Resident #1's Elopement Risk Evaluations when evaluating Resident #1's risk of elopement. This failure could place residents at risk of receiving treatment and care for inactive diagnoses and not receiving treatment and care when necessary to meet clinical, functional, mental, and psychosocial needs. Findings included:Record review of Resident #1's face sheet, dated 02/04/2026, reflected a [AGE] year-old male, admitted on [DATE] and discharged on 12/02/2025. Resident #1 diagnoses included cerebral infarction (blood clot forms in artery, disrupting blood flow to the brain, resulting in stroke) and osteoarthritis (protective cushion at ends of bones wear down, leading to stiffness and pain). Further record review of Resident #1's medical diagnoses revealed on 11/27/2025, the RNC had struck out the primary diagnosis dementia. The diagnosis did not appear on the face sheet. Record review of Resident #1's admission MDS, dated [DATE], revealed Resident #1 had a BIMS score of 13, indicating intact cognitive function and ability to recall information immediately. Active diagnoses included Progressive Neurological Conditions, i.e. stroke (interruption of blood flow to brain) and non-Alzheimer's dementia (can be caused by a stroke and result in cognitive decline, behavioral change, etc.). The MDS assessment revealed Resident #1 did not exhibit wandering behaviors.Record review of Resident #1's BIMS assessments reflected: 10/13/2025 - Moderately impaired 1010/13/2025 - Cognitively intact 1310/24/2025 - Cognitively intact 1512/2/2025 - Cognitively intact 13 Record review of Resident #1's clinical history documentation, dated 10/12/2025, revealed Resident #1's past medical history included Cerebrovascular Accident (stroke, interruption of blood flow to the brain) and dementia, and he used a walker (to ambulate). Record review of Resident #1's Mental Illness/Dementia Resident Review, signed by the MD on 11/11/2025, revealed Resident #1's MD completed the form and marked Yes, the individual has a primary diagnosis or has a dementia diagnosis as defined above. The physician signs and dates the form attesting to the dementia diagnosis. Record review of Resident #1's care plan, completed 11/07/2025, reflected:was at risk for elopement related to Elopement Evaluation risk score, initiated on 11/02/2025had impaired cognitive function/dementia or impaired thought processes r/t Dementia, initiated on 10/13/2025required psychotropic medications (Donepezil HCL) for diagnosis of (Dementia), initiated on 10/13/2025Record review of Resident #1's most recent care plan, revised 11/27/2025, reflected:had impaired cognitive function/dementia or impaired thought processes r/t Dementia, initiated on 10/13/2025required psychotropic medications (Donepezil HCL) for diagnosis of (Dementia), initiated on 10/13/2025was (high, moderate, low) risk for falls r/t Gait/balance problems, initiated 10/13/2025was a Potential Safety Risk When Leaving Facility Related to: Resident leaving facility without advance notice; history of similar behaviors in prior facilities. As evidence by: Independent exit, later self-admission to local hospital, initiated on 11/27/2025had psychiatric diagnosis (Schizophrenia/Depression/Anxiety) Related to: Chronic psychotic illness. As evidenced by: History of mental health conditions and preference to direct own care. Self-check in to local hospital, initiated on 11/27/2025 Exercising Autonomy / Independent Decision-Making Related to: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Preference for self-directed choice, history of leaving facilities independently. As evidenced by: resident verbally stating he does not want to remain in facility; BIMS 13 demonstrating ability to make decisions; resident independently checking himself into local hospital, initiated on 11/27/2025The care plan revised 11/27/2025 did not reflect Resident #1's elopement attempt and actual elopements on 10/24/2025, 11/02/2025, and 11/27/2025. Record review of Resident #1's progress notes reflected:Effective Date 10/24/2025: Security personnels at the gate called nurse to come for him because he wants to go home, ambulates with walker. Nurse went to the gate and spoke to him to come and express his concerns to the social worker as he proposed earlier. He agreed and came back with nurse to the building. Nurse accompanied him back in wheelchair with no problems. On q 2 hourly monitoring. Seemed co-operative with staff, calm, no aggressiveness. [sic]Effective Date 11/02/2025: Spoke with the resident's [Family Member #7 and Family Member #9] regarding the resident's exit seeking behavior; the couple stated that they are not surprised because every facility/psychiatric hospital he goes to he either checks himself out or he attempts to leave. The [Family Member #7] stated that his most recent stay was at a psychiatric hospital, he checked himself out, told the Police he wanted to go to [location], they put him on a bus, but he never made it there because he got off in [location] and here we are. The [Family Member #7] stated that he is unable to come and get him or find alternative placement because he doesn't know what is driving [Resident #1] to leave but he stated that he understand the liability the facility is faced with if he attempts to leave. [sic]Effective Date 11/02/2025: Resident sent to [psychiatric hospital]. Resident had two episodes of elopement from the facility. Resident showed signs of aggression and combativeness when asked why he wants to leave facility. Resident said, I want to leave this place, You people are holding me hostage, I want to leave. Resident was unable to articulate where he intends to go. The police were called to help control resident's behavior and outburst. Resident was finally sent to [psychiatric hospital]. The Doctor, Administrator, the don, and the Family Members where notified of the situation. [sic]Effective Date 11/14/2025, Created on 11/27/2025: Resident is a [AGE] year-old male with psychiatric history including schizophrenia, depression, anxiety, cognitive impairment, with a well-documented history of leaving prior facilities without notifying staff. Family Members previously confirmed that the resident frequently leaves care settings independently and without authorization, noting this behavior has occurred at multiple facilities and psychiatric hospitals .Effective date 11/27/2025, Created on 12/02/2025: [Resident #1] is [AGE] year-old, with admitting diagnosis of Cerebral infarction, history of psychiatric diagnosis of schizophrenia and depression. Before admitting to facility resident has a history of deciding to leave facilities and hospitals due to own personal reasons. Resident is aware of his needs and able to make decisions regarding his care and safety. Resident decided to leave the facility 11/26 facility received information that resident independently checked himself into a local hospital. No injuries were reported. This action is consistent with the resident's baseline pattern of independently leaving prior facilities and making his own arrangements for care or evaluation. Resident's ability to navigate the community, arrive at a hospital, and seek medical attention on his own reflects preserved decision-making capacity and supports his cognitive ability to make autonomous choices regarding his whereabouts and medical. [sic]Records did not show documentation of orders or discussion to change Resident #1's dementia diagnosis. Record review of Resident #1's Elopement Risk Evaluations reflected: Date: 10/13/2025; Lock (Completed) Date: 10/13/2025 Resident #1 was a Moderate Risk, and able to make decisions regarding tasks of daily living, e.g. decisions are consistent and reasonable; and was able to ambulate or mobilize wheelchairs; Patient is cognitive impaired AND 1) ambulates or propels self. Patient may go outdoors on occasion but makes no attempt to leave (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	grounds. Date: 11/02/2025; Lock (Completed) Date: 11/13/2025 Resident #1 was No Risk; and not able to make decisions regarding tasks of daily living, e.g. decisions are consistent and reasonable; and unable to ambulate or mobilize wheelchairs. Additional information [Resident #1] is at risk for elopement related to Elopement Evaluation risk score.Date: 11/27/2025; Lock (Completed) Date: 02/04/2026 Resident #1 was No Risk; Resident #1 was able to make decisions regarding tasks of daily living, e.g. decisions are consistent and reasonable; and was able to ambulate or mobilize wheelchairs.Evaluations on 11/02/2025 and 11/27/2025 were not completed, staff only completed the questions in the No Risk section. Questions to evaluate Resident #1 as a Moderate Risk or Imminent Risk were triggered and but not completed for the electronic system to trigger the resident as moderate or imminent risk. There were discrepancies between the resident's elopement risk evaluations regarding his ability to make decisions and ambulate. Record review on 02/05/2026 of Resident #1's transfer form to discharge to the hospital, dated 11/02/2025, revealed Resident #1 was alert, disoriented, but cannot follow simple instructions, ambulates with assistive device, and requires assistance for ADLs. Resident #1 was noted to may attempt exit as an additional risk. Record review of Resident #1's psychiatry/therapy visits revealed Resident #1 was seen on 11/07/2025, 11/12/2025, and 11/18/2025. Resident #1 was referred for Depression, Tearfulness, Confusion, Elopement, Adjustment Disorder, High Risk Behavior. Resident #1's history of presenting illness included unreliable historian. does not remember attempting to elope, there was previous behavior for this and patient was placed on 1:1 for this. disoriented to situation. Resident #1 was noted to have been prescribed medications including Donepezil to treat for unspecified symptoms and signs involving cognitive function and awareness. Resident #1 was noted to endorse cognitive impairment symptoms of decreased concentration, forgetfulness, and difficulties with ADLs. During an interview on 02/04/2026 at 1:39 P.M. with the DON, she stated elopement risk was determined by elopement risk evaluation assessments. She explained if the first two questions were determined Yes (e.g. resident able to make decisions and unable to ambulate or mobilize wheelchairs), the evaluation was complete, and the resident was a low risk. The DON said if a resident did not want to be in the facility, they were not a risk because they had the ability to make decisions. She said if residents had a low BIMS score or cognitive impairment and were exit seeking, they were an elopement risk; if residents had a 13-15 BIMS score, they were not an elopement risk. The DON said if a resident had dementia and was able to make decisions for themselves, they were not an elopement risk. During an interview on 02/04/2026 at 2:05 P.M. with LVN D, she said she remembered Resident #1. She said she kept her eye on him 24/7 and he was very tricky because (staff) did not know what he was going to do the next minute, and it was a real issue with him. LVN D said he was on one-on-one observation at one time and that was the key (intervention). She said he was an elopement risk and indicated he showed signs including exit-seeking and verbalizing wanting to leave, and she had to redirect him. LVN D said behaviors like Resident #1's, and even his high BIMS score, made him an elopement risk because he was always seeking to leave and looked for an exit and that was an elopement risk. During an interview on 02/04/2026 at 2:30 P.M. with RN E, she said she remembered Resident #1. She recalled she had done one-on-one monitoring with Resident #1. RN E said Resident #1 could make decisions for himself to an extent, but I would say no. She indicated Resident #1 was not safe to be out of the facility by himself. RN E indicated Resident #1 was forgetful, she would provide medication for pain and he would forget he took the medication, he would forget what happened in the hospital, and if she asked why he left (the facility), he would say he wanted to get out of here (facility). She said his dementia was care planned and when those behaviors (i.e. forgetful, dementia, exit-seeking) were seen, they were documented. During an interview on 02/04/2026 at 5:16 P.M. with (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Family Member #7 and Family Member #9, they said Resident #1 had records of a dementia diagnosis and had shown signs of dementia. Family Member #9 said Resident #1 could not make decisions for himself. They said the facility had called them about Resident #1 wanting to see a Family Member who had been dead for over 20 years. Family Member #9 said they had documentation from the facility showing Resident #1 had a diagnosis of dementia and they needed the documentation for the social security office. They said they did not want Resident #1 to leave the facility, and it stressed them out when he disappeared. Family Member #9 mentioned it had been hard to find a new facility closer to them due to Resident #1's elopements. During an interview on 02/05/2026 at 10:46 A.M. with the RNC revealed she struck out the dementia diagnosis for Resident #1 because he had a high BIMS score and was not exhibiting signs of dementia based on nursing assessments. She said she spoke to the MD and he said it was okay to discontinue the dementia diagnosis. She said she was not aware of the PASRR the MD signed on 11/11/2025 stating Resident #1 had a primary diagnosis of dementia. The RNC said she did not document the conversation or justification for changing the medical records. She said she had done a record review for Resident #1 because he had left the building but stated I don't know if I would say he eloped. She then stated she specifically reviewed Resident #1's records on 11/27/2025 because it was a random review. She then said she did record reviews for residents when an event happened, and residents went to the hospital. RNC indicated she was not aware that Resident #1's was care planned for dementia and dementia medication, and that he was actively medicated for dementia. During an interview on 02/05/2026 at 11:35 A.M. with Resident #1's MD, he stated Resident #1's diagnosis of dementia was discontinued on 11/27/2025 after he was informed by the facility that Resident #1's BIMS score was 13. The MD indicated the facility contacted him and he approved the diagnosis to be discontinued based on the BIMS score. He said he was not aware of Resident #1's exit seeking behaviors or elopement, and there was no documentation regarding Resident #1's exit seeking behaviors in his or his NP's notes. The MD said he did see Resident #1 was on medication for dementia. He said he did not know if Resident #1 was safe to leave the facility or ambulate independently.Attempted phone call interview on 02/05/2026 at 4:29 P.M. with RN F regarding progress notes on 11/02/2025 when Resident #1 was sent to the psych hospital. RN F did not return the state surveyor's phone call.During an interview on 02/05/2026 at 5:00 P.M. with RN G, she revealed residents with high BIMS scores can be an elopement risk. She further said that if residents set their mind to it (leaving), nothing will stop them, and they can get creative. RN G said signs included the resident not wanting to be at the facility, packing a small bag, looking at doors to see if there was potential to run out and leave. During an interview on 02/05/2026 at 7:23 P.M. with the previous SW, she said she worked at the facility when Resident #1 was there. She said Resident #1 was fuzzy (confused) about he admitted to the facility and Family Member #7 said his memory was not the best. She said there was discussion with family about making arrangements for the resident to live closer to them and for Resident to not to just leave and not tell the facility. The previous SW indicated in her experience with Resident #1 his cognitive abilities were good, and he had a high BIMS score, but a BIMS score was not the only determinant of cognitive abilities. She said Resident #1 was an elopement risk and he had used a walker; she further said he had dug under the fence of the facility and talked about leaving very often. She indicated it would be a risk for any resident to leave the facility alone with similar behaviors and conditions to Resident #1. The previous SW said there was discussion with family about Resident #1 leaving being a liability (to the facility) and that he could have hurt himself and anything could have happened. During an interview on 02/06/2026 at 1:09 P.M. with the DON, she revealed it was important for resident medical records to be accurate so staff can provide accurate care, were aware of (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the residents and their diagnoses, medication, and had been going on prior to their admission. She said when there was a change in a resident, documentation depends on the change; she said it ultimately should be in progress notes and different assessments were used for different things. The DON said the risk if medical records were not accurate was hard to say, depending on the situation and on what was not accurate. She said for Resident #1 he functioned at a high level and was able to do what he wanted to do. The DON said nursing staff were responsible for making sure resident medical records were accurate. During an interview on 02/06/2026 at 2:40 P.M. with the ADM, he stated RN F's notes were not accurate on 11/02/2025 and there were no elopements and that Resident #1 was not an elopement risk because he had a high BIMS score, he could make decisions, and he did not have dementia. He said accurate medical records were important because it helped the facility provide proper care. He said documentation was important to make sure (staff) had a record of elopement and changes in the residents (i.e. change in diagnosis). The ADM said when the doctor called, it should be documented. The ADM said the risk of inaccurate records depended, but staff were required to document, including when orders were given. He said he and the DON were responsible for looking at resident records to make sure they were accurate and documented accurately. During an interview on 02/06/26 at 03:24 P.M. with RN J, she stated the importance of maintaining accurate records or documentation was it is legal and then the next shift can look back and know what is going on with the resident. Record review of the facility's Medical Record Content policy, dated 06/2020, reflected: PurposeTo ensure adequate and accurate documentation of care provided to each resident while at theFacility. ProcedureThe Facility will maintain a medical record for each resident admitted to the Facility that will containsufficient information to identify the resident, support the diagnosis, justify the medical necessity fortreatment, and facilitate continuity of care among health care providers. ProcedureI. The medical record will be accurate, timely and complete and may include the following content: .L. Ancillary Assessmentsi. Assessments will be initiated at the time of admission.ii. Assessments and progress notes should be consistent with Care Plans developed for the residents.iii. Frequency of progress notes and/or assessment will be per state regulation and Facility policy.CC. Notification to Physician - Documentation and notification to the physician promptly of the following:i. admission of a resident;ii. Change of condition;iii. Unusual occurrences involving the resident;iv. Significant change in weight;v. Side effects or reaction to medication/treatment;vi. Any error in administration of medication;vii. The Facility's inability to obtain or administer, on a prompt and timely basis drugs, equipment, supplies, or service as prescribed under conditions which present a risk to the health, safety or security of the resident; andviii. Attempts to notify the physician will be noted, including the time, method of communication, the name of the person acknowledging contact, if any. If the Attending Physician is not readily available, emergency care will be provided.DD. Physician Orders.