STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675553	A. Building B. Wing	04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caraday of Quitman	1026 E Goode St Quitman, TX 75783

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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on observation, interview, and record review, the facility failed to have physician orders for the resident's immediate care for 1 of 3 residents (Resident #1) reviewed for admission physician orders. The facility failed to ensure Resident #1 had a physician order to wear her knee brace and to not bear weight on her right knee. This failure could place residents at risk for not receiving appropriate care, treatment, and services. Findings included: Record review of a face sheet dated 03/20/2024 indicated Resident #1 was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life), and wedge compression fracture of T11-T12 vertebra, subsequent encounter for fracture with delayed healing (fracture of the spine with delayed healing), chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of Resident #1's Quarterly MDS assessment dated [DATE] indicated Resident #1 was understood and understood others. Resident #1 had a BIMs score of 15, which indicated she was cognitively intact. The MDS assessment indicated Resident #1 did not exhibit wandering. The MDS assessment indicated Resident #1 required partial/moderate assistance with toileting hygiene, upper/lower body dressing, personal hygiene and transfers. The MDS assessment indicated Resident #1 used a manual wheelchair. Record review of Resident #1's care plan with a target date of 04/25/24 indicated she required assistance of 1 person with transfers, dressing, toileting, personal hygiene, and limited assistance with toileting. Resident #1's care plan indicated Resident #1 had an actual fall with interventions to complete fall documentation packet per facility protocol, wear nonskid footwear with all transfers, ask for assistance from staff, monitor for changes in condition and document and report to MD/NP. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's After Visit Summary from the ER visit dated 03/16/2024 indicated instructions x-rays showed a nondisplaced tibial plateau fracture (fracture occurs around the knee joint) and possible compression fractures to the spine to apply ice for 20 minutes every 2 hours while awake to the areas that were sore and wear the knee brace and do not put full weight on the knee brace to use a wheelchair. The Physician's Orders indicated see ER discharge instructions, non-weight bearing to right knee, and ice back and knee for 20 minutes every 2 hours while awake. Record review of the Order Summary Report with active orders as of 03/19/2024 indicated Resident #1 had an order for place ice pack to back and right knee for 20 minutes every 2 hours related to pain every 2 hours as needed for pain and swelling while awake with a start date of 03/17/2024. The Order Summary Report did not indicate orders for non-weight bearing to the right knee or for the knee brace to right lower leg. During an interview on 03/20/2024 at 11:25 AM, LVN A said she received a call from the ER after Resident #1 arrived at theER on [DATE] from her elopement. LVN A said she was told by the ER that Resident #1 had fractures to her back and to her right knee, but they were old fractures. LVN A said she had not received that information from LVN B in report, after Resident #1 returned to the facility from her ER visit (the previous night) on 03/16/2024. LVN A said she did not know if the ER had sent discharge paperwork with Resident #1 when she discharged from the ER (the night before) on 03/16/2024. During an observation and interview at the hospital on 03/20/2024 at 2:09 PM, Resident #1 had a brace on her right lower extremity. Resident #1 was alert and oriented to person and place but had confusion. Resident #1 said she had injured her right leg after a fall at the facility. During an interview on 03/20/2024 at 3:56 PM, LVN B said when Resident #1 returned from her ER visit on 03/16/2024 she noticed she had a knee brace on. LVN B said she was not told in the report she received from the ER the evening of 03/16/2024 that Resident #1 had fractures to her back or right knee. LVN B said the ER had sent paperwork after Resident #1's ER visit, but she had not seen the instructions or the orders for the knee brace or non-weight bearing status. LVN B said it was an error on her part and she should have looked over the discharge paperwork more thoroughly. LVN B said she should have let the other nurses, DON, ADON, and doctor know that Resident #1 had come back with fractures, and she should have put in the orders into the electronic health record. LVN B said when a resident admitted or readmitted the nurse that received the discharge orders was responsible for putting them into the computer. LVN B said it was important for the orders to be put in the electronic health record to ensure the doctor's orders were followed and the resident's received the treatments they needed. (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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/20/2024 at 6:05 PM, the DON said the nurse on duty when the resident arrives to the building was responsible for putting the physician's order into the electronic health record. The DON said Monday-Friday before 5 PM she reviewed the admissions and ER records, after 5 PM on Friday the weekend RN should review the admissions orders, and depending on the time of admission over the weekend if the DON reviewed them on Monday or the weekend RN reviewed them. The DON said even though the RN over the weekend reviewed orders she also reviewed them on Mondays. The DON said she was not notified about Resident #1's fractures, and she had asked LVN B if she was aware and LVN B had told her no. The DON said LVN B should have reviewed the ER records from 03/16/2024 not only for new orders or medication changes, but also for other orders and diagnoses, and if she needed clarification, she should have called the ER. The DON said it was important for new orders to be put in the electronic health record so orders and diagnoses did not get missed and the treatment plans did not get missed. During an interview on 03/20/2024 at 6:24 PM, the Administrator said the charge nurses were responsible for putting in orders upon a resident's admission, and he expected for the nurses to review records for new orders and to follow the physician's orders to ensure the residents received the care they required. Record review of the facility's undated Morning Meeting-Administrative/Clinical Stand-up, indicated, .During Morning Meeting (work concurrently to review PCC (point click care electronic medical record system), then discuss the areas listed below) . Run Order Summary Report select Order Date Range and include yesterday's date (include weekend on Monday), review active and discontinued orders to confirm they are entered correctly . discuss any critical events, accidents/incidents that occurred since morning meeting that require immediate action or notification .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on observation, interview, and record review, the facility failed to ensure that the resident environment remained as free of accident hazards as possible and provide supervision to prevent avoidable accidents for 1 of 3 residents (Resident #1) reviewed for quality of care. The facility failed to ensure Resident #1 was adequately supervised after she had a change in mental status and told staff she was leaving the facility, which resulted in her leaving the facility in her wheelchair and going two buildings down the street (on the same side of the road approximately 800 feet) away from the facility on 03/17/2024 without the facility staff's knowledge. An IJ was identified on 04/01/2024. The IJ began on 03/17/2024 and removed on 03/17/2024. While the IJ was removed on 03/17/2024, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm because all staff had not been trained on monitoring after a change in condition. This failure could place residents at risk of potential accidents, injuries, harm or death. Findings included: Record review of a face sheet dated 03/20/2024 indicated Resident #1 was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life), and chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of Resident #1's Quarterly MDS assessment dated [DATE] indicated Resident #1 made herself understood and understood others. Resident #1 had a BIMs score of 15, which indicated she was cognitively intact. The MDS assessment indicated Resident #1 did not exhibit wandering. The MDS assessment indicated Resident #1 required partial/moderate assistance with toileting hygiene, upper/lower body dressing, personal hygiene and transfers. The MDS assessment indicated Resident #1 used a manual wheelchair. Record review of Resident #1's care plan with a target date of 04/25/24 indicated she required assist of 1 person with transfers, dressing, toileting, personal hygiene, and limited assistance with toileting. The care plan did not indicate resident wandered, had a history of wandering or elopement. Resident #1's care plan indicated Resident #1 had an actual fall with interventions to complete fall documentation packet per facility protocol, wear nonskid footwear with all transfers, ask for assistance from staff, monitor for changes in condition and document and report to MD/NP. Record review of Resident #1's Wandering Risk Scale dated 01/10/2024 indicated Resident #1 could move without assistance while in a wheelchair, had no history of wandering, and had no reported episodes of wandering in the past 6 months. Resident #1 was at low risk for wandering. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's After Visit Summary from the ER visit date 03/16/2024 indicated the discharge diagnoses included a urinary tract infection. The After Visit Summary indicated instructions x-rays showed a nondisplaced tibial plateau fracture (fracture occurs around the knee joint) and possible compression fractures to the spine to apply ice for 20 minutes every 2 hours while awake to the areas that were sore and wear the knee brace and do not put full weight on the knee brace to use a wheelchair. The Physician's Orders indicated see ER discharge instructions, non-weight bearing to right knee, and ice back and knee for 20 minutes every 2 hours while awake. Record review of the Order Summary Report with active orders as of 03/19/2024 indicated Resident #1 had an order for place ice pack to back and right knee for 20 minutes every 2 hours related to pain every 2 hours as needed for pain and swelling while awake with a start date of 03/17/2024. The Order Summary Report did not indicate orders for non-weight bearing to the right knee or for the knee brace to right lower leg. Record review of the Neurological Assessments (tool used to assess neurological status) dated from 03/12/2024-03/17/2024 indicated they were completed per facility protocol. On 03/17/2024 Resident #1 was on 8-hour checks with the last 8 hour check completed at 11:30 AM. Record review of Resident #1's progress notes indicated: 03/16/2024 at 5:18 PM, .Resident #1 was showing signs and symptoms of confusion. NP notified and was given referral to have psych evaluation. Signed by LVN A. 03/16/2024 at 9:00 PM, Was called to resident's room due to CNA on duty overheard resident state oh oh I am falling. When this nurse entered the room, the resident was sitting on the floor propping self-up with both arms. Denies hitting head. Stated she fell forward while attempting to pick up glasses off the floor. Denies any pain and discomfort. Range of motion to upper and lower extremities within the normal limits. No abnormal alignments noted to upper or lower extremities. Assisted resident off the floor. Initiated fall protocol. Notified NP on call for the physician, who ordered resident to be sent out to the local hospital for further evaluation due to this being her second fall in 3 days. Signed by LVN B 03/17/2024 at 3:35 PM, received a phone call from a [NAME] that a person in a wheelchair was rolling down the street. Nurse ran to vehicle and rushed to resident's aide. No visible injuries were observed. Resident alert and oriented. Resident refused to get into vehicle with nurse and to return to facility. Resident continued attempt to enter road as nurse held wheelchair to keep her safely in parking lot. Resident's safety maintained. Resident stated, I'm leaving and going to the gas station. Nurse called 911, upon arrival, resident agreed to go to the hospital via EMS. Resident remained alert and oriented while being question by EMS, transferred to gurney with 1 person assist. Signed by LVN A. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/20/2024 at 11:25 AM, LVN A said she was in the middle of administering medications when she heard the facility phone ring, and it was a citizen that was driving down the road. LVN A said the citizen told her they thought one of the facility's residents was wheeling down the road. LVN A said she immediately notified the other nurse she was leaving to get the resident. LVN A said she called the DON when she got in the car to go get the resident. LVN A said she found Resident #1 two buildings away from the facility (on the same side of the road approximately 800 feet away from the facility). LVN A said she could not convince Resident #1 to return to the facility with her because she was insisting on going across the road to the gas station. LVN A said she asked the DON what to do and was told to call 911. LVN A said when EMS arrived, Resident #1 agreed to go to the ER with them, and Resident #1 remained hospitalized . LVN A said she did not know when Resident #1 left the facility, but she had just seen her 5-10 minutes prior to receiving the phone call that there was a resident in a wheelchair on the road. LVN A said she knew she had seen her 5-10 minutes prior because Resident #1 had requested assistance with getting her purse, and she had assisted her with that. LVN A said recently Resident #1 had been confused probably since Friday or Saturday (03/15/2024 or 03/16/2024) due to a UTI that was diagnosed from an ER visit Resident #1 had on 03/16/2024. LVN A said Resident #1 was able to respond appropriately when asked the place and time, but she was having some confusion. LVN A said Resident #1 was able to transfer herself and was able to wheel herself around manually in her wheelchair. LVN A said Resident #1 had not tried to elope from the facility before. LVN A said in the past Resident #1 had been allowed to sign herself out of the facility. LVN A said the day Resident #1 eloped she had not signed herself out. LVN A said she received a call from the ER after Resident #1 arrived at theER on [DATE] from her elopement. LVN A said she was told by the ER that Resident #1 had fractures to her back and to her right knee, but they were old fractures. LVN A said she had not received that information from LVN B in report, after Resident #1 returned to the facility from her ER visit on 03/16/2024. LVN A said she did not know if the ER had sent discharge paperwork with Resident #1 when she discharged from theER on [DATE]. During an interview on 03/20/2024 at 11:52 AM, the Administrator said he received a call from the DON around 2:25 PM on Sunday 03/17/2024, reporting someone in the community had called the nurse on duty to report a resident in a wheelchair on the road, and the nurse had gone to get the resident. The Administrator said he was told the nurse attempted to have the resident return to the facility for safety reasons, but the resident refused, 911 was called, and the resident was taken by EMS to the hospital where she remained hospitalized . The Administrator said Resident #1 had no history of wandering or any previous incidents of elopement. The Administrator said the front and back doors stay unlocked. The Administrator said they did not have any residents who wandered, and if they had a resident that wandered, they would have to be put on one-on-one supervision until they could send them to a different facility where their needs could be met because the facility was not equipped to care for residents that were at risk for wandering/elopement. The Administrator said according to the location where Resident #1 was found she was probably out of the facility for approximately 5-7 minutes. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/20/2024 at 12:44 AM, the DON said prior to Resident #1's elopement from the facility, LVN A had notified her Resident #1 was not herself. The DON said resident #1 was usually alert and oriented, but on Thursday (03/14/2024) Resident #1 was noticed to have a change in her cognition. Resident #1 was sent out to the hospital on 03/14/2024 due to having abnormal movements to her body that she could not control. The DON said Resident #1 did not have a history of elopement and she did not display exit seeking behaviors. The DON said the front door was locked from the outside but not from the inside. The DON said the true front door was used as a back door and the back door was used as the front door. The DON said the back door (used as the front door) was kept unlocked during the day, and then the night shift locked it at 9 PM and around when it was time for shift change at 6 AM the door was unlocked. The DON said they did not have any residents that wandered. The DON said LVN A had called her when she was on her way to find Resident #1, and she stayed on the phone with her to provide assistance. The DON said Resident #1 did not want to return to the facility because she insisted on going to the gas station across the street. The DON said she instructed LVN A to tell Resident #1 she would take her, but Resident #1 refused. The DON said LVN A then called for EMS services, and Resident #1 was taken to the ER, and was admitted to the hospital and was still hospitalized . During an interview on 03/20/2024 at 1:08 PM, Anonymous Staff Member #1 said on Sunday (03/17/24) Resident #1 had told everybody she was going to leave the facility. Anonymous Staff Member #1 said they could tell Resident #1 was mad. Anonymous Staff Member #1 said Resident #1 told them LVN B had told her she did not want to watch her when she returned from the ER Saturday (03/16/2024) night. Anonymous Staff Member #1 said Resident #1 told them because of that she was leaving the facility. Anonymous Staff Member #1 said they reported it to LVN A, and Resident #1 had reported it to LVN A as well. Anonymous Staff Member #1 said they were not aware when Resident #1 left the facility. Anonymous Staff Member #1 said the last time they had seen Resident # 1 was after lunch when they picked up her lunch tray. Anonymous Staff Member #1 said Resident #1 smoked, and she went to her smoke breaks and had never attempted to leave the facility. During an observation on 03/20/2024 at 2:00 PM, the gas station Resident #1 was attempting to go to was on the opposite side of the road from the facility. For Resident #1 to get to the gas station she would have had to wheel herself across the 4-lane state highway with a speed limit of 50 miles per hour. During an interview at the hospital on 03/20/2024 at 2:09 PM, Resident #1 was alert and oriented to person and place, but Resident #1 had confusion. Resident #1 was asked a question and started her response according to the question that was asked, but then veered off topic. During the interview Resident #1 asked surveyor to verify which city she was currently in. Resident #1 had a brace on her right lower extremity. Resident #1 said she had injured her right leg after a fall at the facility. Resident #1 said she wheeled herself out of the facility and made it two buildings down from the facility before they came and got her. Resident #1 stated she was trying to get to the gas station. Resident #1 said she left because the head night nurse, the night she had a fall, told her she needed to go, and she did not want her at the facility. Resident #1 said she told LVN A before she left that she wanted to leave the facility because LVN B did not want her at the facility. Resident #1 said LVN A had told her she could not leave the facility. Resident #1 said she thought she was out of the facility for a couple of hours. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with Hospital RN C on 03/20/2024 at 2:33 PM, Hospital RN C said Resident #1's current mental status was altered. Hospital RN C said Resident #1 was alert and oriented to person and place and could remember some things, but when she started having a conversation with her, she could tell she was confused. Hospital RN C said Resident #1 was admitted to the hospital with a diagnosis of altered mental status, and the doctors were still trying to figure out the cause for her altered mental status and there was no discharge date at that time. During an interview on 03/20/2024 at 3:35 PM, LVN A said Resident #1 had not mentioned to her that LVN B told her she did not want to watch her. LVN A said Resident #1 did not mention to her wanting to leave the facility due to this. LVN A said Resident #1 asked her for her purse and told her I have to leave this team of teenage girls. LVN A said she asked Resident #1 for clarification and Resident #1 repeated the same thing. LVN A said that's how she knew Resident #1 was confused. LVN A said the CNAs and herself were rounding more frequently on Resident #1 due to her confusion. During an interview on 03/20/2024 at 3:56 PM, LVN B said she would not tell Resident #1 that she did not want to take care of her. LVN B said when she sent Resident #1 to the ER Saturday evening (03/16/2024) after she fell , initially Resident #1 did not want to go to be evaluated by the ER, but she was able to convince her to go. LVN B said when Resident #1 returned from her ER visit on 03/16/2024 she noticed she had a knee brace on. LVN B said she was not told in the report she received from the ER the evening of 03/16/2024 that Resident #1 had fractures to her back or right knee. During an interview on 03/20/2024 at 5:22 PM, LVN A said all the staff were responsible for monitoring the residents to ensure they knew where they were and to ensure their safety. LVN A said it was important to provide adequate supervision to the residents to know who was in the facility and where they were. LVN A said Resident #1 was confused at the time of her elopement and it was not safe for her to be out of the facility on her own, and she could have gotten hit by a car. During an interview on 03/20/2024 at 6:05 PM, the DON said all of the staff were responsible for ensuring residents were supervised to prevent accidents and hazards. The DON said they ensured the residents were supervised by rounding on them frequently and encouraging them to participate in the activities at the facility. The DON said she felt like the staff was providing more supervision to Resident #1 due to her confusion. The DON said she was not notified about Resident #1's fractures, and she had asked LVN B if she was aware and LVN B had told her no. During an interview on 03/20/2024 at 6:24 PM, the Administrator said all staff were responsible for supervising/monitoring the residents. The Administrator said he expected the staff to monitor the residents closely if they noticed an onset of confusion. The Administrator said Resident #1's elopement from the facility placed her and other residents at risk for accidents or injury. During an interview on 03/29/2024 at 8:52 AM, LVN A said one of the CNAs was saying Resident #1 told her she was leaving the facility. LVN A said she thought she would address it when Resident #1 told her she was leaving because she was able to go out on pass if she wanted to, she could not keep her at the facility. LVN A said she was monitoring Resident #1 closely not because she said she was leaving, but because she had a fall. LVN A said Saturday, before Resident #1 eloped she was having confusion that evening. LVN A said they were doing neuro checks on Resident #1 per the facility protocol due to her falls. LVN A said she had charted she was alert because even though Resident #1 had confusion, she was alert and oriented to person and place. LVN A said she did not think there was a place on the neuro checks to document the confusion. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/29/2024 at 10:51 AM, the DON said if the nurse was aware Resident #1 was saying she wanted to leave the facility, she should have notified her, the NP and should have increased supervision to every 15-minute checks on paper (15 minute checks were not performed prior to Resident #1's elopement). The DON said if the residents had any change in condition the nurses should document it in the electronic health record, place it on the 24-hour report to communicate it to the other nurses, monitor the resident closely, notify the MD and notify her. During an interview with the Medical Director on 03/29/2024 at 11:55 AM, he said the staff was updating him on Resident #1's changes. The Medical Director said he had given the staff instructions to monitor her closely and to monitor her mental status, and to send her back to the ER if she was still having issues. The Medial Director said Resident #1 was her own representative and she did not normally wander. The Medical Director said Resident #1 had days where she was very lucid and answering questions appropriately and then there were episodes when she was not able to make decisions appropriately. The Medical Director said from what he recalled from the ER she was alert and oriented and answering question, but she was having paranoia. The Medical Director said if Resident #1 had told the staff she wanted to leave the facility they should have increased supervision on her. The Medical Director said from what he understood the staff was monitoring Resident #1 closely, they just were not documenting throughout the day. During an interview on 04/01/2024 at 12:40 PM, the Administrator said Resident #1 had returned from the hospital on 03/26/2024. The Administrator said Resident #1 was on 15-minute checks upon her return from the hospital until they could determine if it was safe for Resident #1 to remain in the facility or what the next steps would be for her safety. Record review of 33 Wandering Risk Scale assessments indicated no residents were at high risk for elopement. Record review of the facility's policy revised March 2022, titled, Wandering and Elopements, indicated, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents .