

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675620	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER Beaumont Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1175 Denton Dr Beaumont, TX 77707	
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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents received adequate supervision to prevent accidents for 1 of 4 residents reviewed for accidents. (Resident #1). The facility failed to provide adequate supervision for Resident #1, who resided on the secured unit due to high risk for elopement and history of elopement, from leaving the facility unsupervised on 11/24/2025. Resident #1 was found at a local hospital emergency room where he had been taken by local police. The facility was not aware that the resident was missing for approximately 1.5 hours until a family member and local police called facility staff about his whereabouts. The noncompliance was identified as PNC (past noncompliance). The IJ began on 11/24/2025 and ended on 11/25/2025. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of potential accidents, injuries, harm, or death. Findings included: Record review of Resident #1's face sheet dated 01/27/2026 indicated Resident #1 was a [AGE] year-old male who admitted on [DATE] with diagnoses including: early onset Alzheimer's Disease (progressive disease that destroys memory and other important mental functions), dementia (loss of cognitive functioning), bipolar disorder (mental disorder associated with episodes of mood swings ranging from depressive lows to manic highs), anxiety (persistent and excessive worry that interferes with daily activities), depression (mental illness that negatively affects how you feel, the way you think and how you act), alcohol abuse, and impaired cognitive function. Record review of Resident #1's admission MDS assessment dated [DATE] indicated Resident #1 had clear speech, usually understood others, and was usually understood by others. He had a BIMS score of 03 indicating severe cognitive impairment. He had behaviors of inattention and wandering daily. He required supervision assistance with ADLs and could feed himself. He was continent of bladder and bowel. He was independent with mobility and walked unassisted. He was independent with eating and putting shoes on/taking off. Record review of care plans for Resident #1 indicated he had a care plan initiated on 11/06/2025 and revised on 11/10/2025 indicating he was at risk for wandering. Goals included: The resident will not leave facility unattended and the resident's safety will be maintained through the next review period. He had another care plans initiated on 11/06/2025 which indicated he was at risk for elopement and required a secure unit. Care plan goals included: Will not feel isolation and will feel safe and secure in the care received while on the secure unit. Interventions included: Supervise closely and make regular compliance rounds whenever resident is in room, assess, record and report potential elopement, determine the reason the resident is attempting elopement and intervene as appropriate. This care plan was updated on 11/25/2025 and indicated he had eloped from the secure unit and a new intervention initiated on 11/25/2025 indicated 1:1 monitoring was in use. Review of Resident #1's Progress Notes in the electronic record indicated the following: *Progress note dated 11/05/2025 at 4:44 p.m., authored by LVN B indicated behaviors of wandering. *Progress note dated 11/07/2025 at 8:49 p.m., authored by RN C indicated Resident #1</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 675620	Facility ID: 675620 If continuation sheet Page 1 of 8

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>observed to be confused and disoriented and required frequent redirection. Resident #1 was given prescribed meds but remained restless and agitated. He continued to wander and repeat statements despite verbal reassurance.*Weekly summary note dated 11/12/2025 at 6:49 a.m. authored by LVN D indicated in the last week resident wanders daily.*Weekly summary note dated 11/19/2025 at 6:42 a.m. authored by LVN D indicated in the last week resident wanders daily.* Progress note dated 11/23/2025 at 1:15 p.m., authored by LVN E indicated Resident #1 was constantly going into Resident #2's room (female). Staff observed him open the closed door and walk in and go toward female resident's bed. LVN E instructed him to come out of her room and not to open her door when it was closed. Female resident's family member was visiting, and he notified LVN E Resident #1 had come in the room a few times. The family member expressed concerns about safety, and he did not appreciate Resident #1 coming into the female's room. The family member requested to keep Resident #1 out of the room.*Progress administration notes continued with entries on 11/16/2025 at 9:23 a.m., 11/16/2025 at 1:02 p.m., 11/17/2025 at 12:02 p.m., 11/18/2025 at 10:17 p.m., 11/19/2025 at 7:13 a.m., 11/20/2025 at 6:58 a.m., 11/20/2025 at 3:03 p.m., 11/21/2025 at 7:18 a.m., 11/22/2025 at 9:35 a.m., 11/22/2025 at 5:59 p.m., 11/23/2025 at 9:01 a.m., 11/23/2025 at 6:13 p.m., 11/24/25 at 8:47 a.m., 11/24/25 at 4:17 p.m. regarding behaviors observed but no indications of the type of behaviors.*Progress Notes dated 11/25/2025 at 2:21 a.m., authored by the DON, indicated she was notified that Resident #1 had eloped and was at local hospital for evaluation and treatment under emergency direct order, per shift nurse. Shift nurse received phone call from Resident #1's family member and was informed that Resident #1 was in police custody and being sent to local ER for evaluation around midnight. Resident #1 eloped from facility, shift nurse attempted to enter resident's room and was unable so went through adjoining room and noted that resident had room door barricaded and window broken. Observation of secure unit courtyard indicated outside chair/bench placed against fence to climb over fence. MD notified, new order to refer to behavioral unit, and RP gave verbal consent for resident to be referred to behavioral hospital. Record review of Resident #1's elopement incident report and LVN F's statement dated 11/25/2025 indicated LVN F was at the facility on 11/24/2025 at 10:00 p.m. for her shift after receiving report from the previous shift nurse, and made rounds and checked on residents. LVN F said Resident #1 was in bed when she peeked in his room during rounds. She received a phone call around 12:00 a.m. from a family member inquiring about Resident #1's location. She went to Resident #1's room and was unable to enter the room the door was barricaded, she went around to the adjoining bathroom and entered Resident 1's room. She found the door had been barricaded with furniture, TV face down on floor, window broken. Resident #1 was missing. Observation of secure unit courtyard found a bench lying slanted on the fence as a ladder. Record review of Resident #1's ER records dated 11/25/2025 indicated Resident #1 was admitted to the ER at 11:36 p.m The narrative indicated he had dementia, and was brought to the ER via local police department. Resident #1 was at local fast food restraint attempting to break into someone's car, and ended up being held up at gunpoint. Resident #1 broke the window of the first floor in a secure nursing facility, used a chair in the courtyard and scaled the fence, then made his way to where local police department picked him up. The records indicated he was at a normal mental baseline, and there was no indication for a psychiatric admission. Resident #1 was discharged on 11/25/2025 back home. Record review of the staff schedule for 11/24/2025 indicated LVN F and CNA A were assigned to work the secure unit on the 10:00 p.m. to 6:00 a.m. shift. Record review of the timesheets for 11/24/2025 indicated LVN F clocked in at 9:56 p.m. and clocked out at 6:53 a.m. on 11/25/2026. CNA A clocked in at 10:05 p.m. and clocked out at 6:09 a.m. on 11/25/2026. Record review of the police incident report dated 11/24/2025 at 10:20 p.m. indicated the local police department was</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>called to a location (0.3 miles from facility) for possible crime on private property, victim was a white male (Resident #1). During an interview on 1/27/2025 at 9:30 a.m., the Administrator said the ADON called him on 11/24/2025 at 11:58 PM and informed him that Resident #1 had eloped from the facility and was in custody of the local police department. He called the facility and learned that Resident #1 was in his room resting during the 10 PM shift change. Staff reported that Resident #1's door had been barricaded with furniture, and he took trim from his window and pried the window open. He said the bench in the secure unit courtyard and a trash can was found against the wooden fence. He said the police informed him Resident #1 was found across the street at a local ER facility attempting to break into a car and the cops were called. He said no one at the facility was aware Resident #1 was missing until they received a call from family members and local police department. During an interview and observation on 1/27/2026 at 10:45 a.m., LVN E was sitting in a chair in Resident #1's room (across from nurses' station). Resident #1 was sleeping in his bed. LVN E said she was providing 1:1 monitoring for Resident #1 for the day shift because he was at risk for elopement. She said if he was not being supervised, he would elope. She said since his admission to the facility he was always looking for his keys, wallet, and car so he could leave. She said he had behaviors of wandering, going to exit doors but easily redirected, and talking about ways to get out. She said he is independent with his care, so she is there to assist. She says she always stays with him, must always have eyes on him. During an interview on 1/27/2025 at 11:30 a.m., LVN D said she was the nurse for the unit. She said Resident #1 had behaviors of wandering, exit seeking, pacing and looking for keys, wallet and car to leave. She said he was admitted to the behavior hospital twice, once after the elopement and another time after exit seeking, hard to redirect and being aggressive with staff. She said Resident #1 was very lucid at times, but then has periods of confusion. She said he had a history of eloping and that was why he was admitted to the secure unit. She said he required frequent monitoring due to exit seeking and wandering into others' rooms. During an interview and observation on 01/27/2026 at 1:00 p.m., LVN E said Resident #1 had been up to the dining room for lunch and just received a shower and shave. Resident #1 in bed, freshly shaven, and well groomed. Resident #1 said he was having a good day and denied abuse or neglect from facility staff and/or other residents. Resident #1 did not recall the elopement incident from November 2025. LVN E said she always remained with him. LVN E said he went to the window and looked out a few times and opened up the dresser drawer looking for his keys and wallet, but he was easily redirected. During an interview on 1/27/2026 at 1:30 p.m., CNA H said she worked the secure unit all shifts. She said she checked residents every hour to see if residents were in the rooms they are assigned to. She said residents wandered in and out of each other's rooms sometimes. She said Resident #1 had to be monitored closely and redirected because he would wander into the wrong room. She said he would talk about his work history and seemed very intelligent and then in the next conversation he would be confused. She said he wandered, paced up and down halls, and talked about going home. During an interview on 1/27/2026 at 4:00 p.m., CNA M said she was the CNA for the 2 - 10 pm shift on 11/24/2025, the day of his elopement. She said she saw Resident #1 around 9:00 p.m He had been up late that evening and came to the dining room and she offered him a snack. She said he was given a snack and redirected to his room. She said Resident #1 did not have a routine sleep pattern; some evening he would go to his room and go to sleep and other evening he would wander and pace the halls. She said Resident #1 did talk about leaving and going home frequently and had a history of exit seeking/elopement prior to admission; that was why he was admitted to the secure unit. She said that Resident #1 would attempt to elope if he was not under 1:1 supervision/monitoring. During an interview on 1/27/2026 at 4:15 p.m., LVN B said she was the</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>said she went wherever he went. CNA G said that she felt if Resident #1 was not on 1:1 monitoring, he would attempt to elope. CNA G said he looked for his wallet and keys and asked where his car was so he could go home. CNA G said he had periods of confusion, and other times he talked about him being a builder or contractor, how he could escape, and repairs needed at the facility. Resident #1 denied eloping from the facility in November 2025 and expressed he was pleased with the care provided by facility safe and felt safe. During an interview on 1/28/2026 at 12:18 p.m., the responding police officer said that the police department was contacted twice regarding Resident #1. He said the first encounter, at a freestanding ER (0.3 miles from the facility), Resident #1 was loitering in the lobby and staff called police. He said the first officer on scene thought he was transient and asked him to leave the establishment and he complied. He said they later received a call from local fast-food restaurant (approximately .5 miles down the road) and bystanders, that a gentleman (Resident #1) was trying to get inside the cars and someone had pulled a gun on him. He said he went to the scene to find the same victim (Resident #1) from the earlier report. He said Resident #1 was able to provide his name and previous residential address (out of town). He said he took Resident #1 to a local ER, and they identified Resident #1 and contacted emergency contacts listed during a previous hospital visit. He said he contacted a family member, and they provided information that he was a resident at a local nursing facility's secure unit. He said he contacted the facility and facility administrator with the location of the resident and his admission to the local ER for evaluation. He said he was concerned for Resident #1's safety, and luckily police were able to respond to the call quickly and no one was injured. During an interview on 1/28/2026 at 1:00 p.m., the DON said she came to the facility when Resident #1 was reported missing on 11/24/2025. She said the ADON notified her, around 11:45 p.m. on 11/24/2025, Resident #1 had eloped and was at a local ER. She said she called the administrator, but he was already aware of the incident. She said she informed the Administrator to notify her of Resident #1's return to the facility and she would provide the initial 1:1 monitoring upon his return. She came to the facility and checked on the secure unit residents with no other concerns identified. She said the RCN provided training to the management staff, and then they initiated in-servicing staff and elopement drills. She said Resident #1 did not return to the facility until 11/25/2025 at 7:45 a.m. due to a transportation delay. She said upon Resident #1's return to the facility, he was placed on 1:1 monitoring and room change closer to secure unit nurses' station. She said she completed the pain and skin assessment on Resident #1 upon his return to the facility with no pain or injuries found. She said she completed elopement risk on all the residents after the elopement incident. She said she was not initially aware Resident #1 being held at gunpoint or threatened with a gun, just that he tried to break into someone's care. She said she was later notified of Resident #1 being held at gunpoint during the morning meeting on 11/25/2026. She said Resident b#1 was transferred to a behavioral hospital for evaluation on 11/25/2026 between 3-4 p.m. She said Resident #1 attempted to elope at the behavioral hospital also. She said Resident #1 had remained on 1:1 monitoring while at the nursing facility. During an interview on 1/28/2026 at 2:30 p.m., the Administrator said he was aware that Resident #1 was held at gun point after his elopement, but was not aware that the local police had two encounters with Resident #1. He said he did recall Resident #1's family mentioning the windows during the initial tour, but they were provided information regarding bars on windows were restricted and windows were secured with required window locks. He said he felt that the facility had done everything they could to keep Resident #1 safe and were still monitoring him 24 hours a day, 7 days a week. Review of the facility's Elopement Prevention Policy undated indicated Every effort will be made to prevent elopement episodes while maintaining the least restrictive</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>environment for residents who are at risk for elopement.Physical Plant 1. All facility exits that residents have access to will have a device in place to alert staff of possible elopement attempts.keypad exit magnetic locks, secured unit, .3.All exit devices will be maintained by the manufacturer's recommendations and function of each door device will be verified weekly and a log maintained. Staff Training: Staff will receive training during their orientation process and then annually regarding elopement prevention, operation of all exit devices, and actions to take if elopement occurs. Review of the facility's Elopement Response Policy undated indicated Nursing personnel must report and investigate all reports of missing residents. When an elopement has occurred or is suspected, our elopement response plan will be immediately implemented.4. Should an employee discover a resident is missing from the facility, he/she should: A. report to the charge nurse .C. make a thorough search of the building and premises. If not located: D. notify Administrator and Director of Nursing; E. notify responsible party; F. notify attending physician; G. notify . Area Director of Operations . The facility took the following actions to correct the noncompliance prior to surveyor entrance: *Record reviews of electronic records indicated all residents were assessed for elopement risk on 11/25/2025. No issues identified. *Record review of the provider investigation folder, the facility's plan of removal dated 11/25/2025 indicated the following corrective actions were taken: *Resident #1 returned to facility on 11/25/2025 at 7:45 a.m., placed on 1:1 monitoring until transferred to behavioral hospital. *All residents received an elopement risk assessment completed by DON, ADON, and designee. No additional findings were identified. *All secure unit residents assessed and monitored after the incident by LVNs, DON, ADON, and designee. No additional findings were identified. *Door code was changed 11/25/2025. *Damaged furniture was replaced 11/25/2025. *The Administrator, DON, and ADON were in-serviced 1 on 1 by the Regional Compliance Nurse on following in-services: Abuse and Neglect; Resident Rights: Elopement Prevention and Elopement Response. *The Medical Director was notified of the Immediate Jeopardy on 11/25/2025 by the DON. *An ADHOC QAPI meeting was conducted by the interdisciplinary team to include the Medical Director on 11/25/2025. *Elopement drills were conducted 11/25/2025 on all shifts by Administrator/Designee.In-services: *The following in-services were initiated on 11/25/2025 for all direct care staff by the DON, ADON, and/or Regional Compliance Nurse in person and/or via phone. All staff who were not present for in-services were not permitted to work their assignment until in-serviced. All new hires will be in-services during facility orientation. All agency staff will be in-serviced prior to working their floor assignment. Observations during the investigation from 1/27/2026 through 1/28/2026 indicated the nine secure unit resident room windows were secure and new window locks observed. The observation of the secure unit courtyard indicated two heavy cemented benches with a 6-foot fence, and keypads or locks on exit gates. During an interview and observation on 11/27/2026 at 11:00 a.m., MNT K said that he did repairs to Resident #1's room after the incident. He said that the window stool/apron had been removed, and the window lock forcefully removed, and window pried open with the outer screen bent. During observation of Resident #1's previous room (room incident occurred), MNT K explained the repairs and said he had replaced the window locks with ones that needed a special tool to remove. He said that he replaced the screen outside and replaced all the window locks in the secure unit resident's room. He said that he had received in-service, and participated in elopement drills several times after the elopement. Record review of an invoice dated 11/25/2025 indicated the facility ordered and received 32 sliding window locks. Record review of an Education In-Service Attendance Record with subject of abuse, neglect, resident rights, elopement prevention and response conducted by regional dated 11/25/2025, indicated that 3 management staff members (1 administrator, 1 director of nursing and 1 assistant director of nursing) all</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>signed the in-service record regarding elopement response, elopement response, resident rights, abuse and neglect. Record review of an Education In-Service Attendance Record with subject of Elopement Response dated 11/25/2025, indicated that 59 staff members (1 Administrator, 1 Business office manager, 1 MA, 17 LVNs, 1 MA, 20 CNAs, 7 Housekeeping/laundry, 4 dietary staff, 1 Marketer, 1 Social worker, 1 activity director, 1 maintenance worker, and 3 therapist) signed the in-service record regarding elopement response. Record review of an Education In-Service Attendance Record with subject of Elopement Prevention dated 11/25/2025, indicated that 59 staff members (1 Administrator, 1 Business of manager, 1 MA, 17 LVNs, 1 MA, 20 CNAs, 7 Housekeeping/laundry, 4 dietary staff, 1 Marketer, 1 Social worker, 1 activity director, 1 maintenance worker, and 3 therapist) signed the in-service record regarding elopement prevention. Record review of an Education In-Service Attendance Record with subject of Abuse, neglect and resident rights dated 11/25/2025, indicated that 59 staff members (1 Administrator, 1 Business of manager, 1 MA, 17 LVNs, 1 MA, 20 CNAs, 7 Housekeeping/laundry, 4 dietary staff, 1 Marketer, 1 Social worker, 1 activity director, 1 maintenance worker, and 3 therapist) signed the in-service record regarding abuse, neglect and resident rights. Record review of a Wander/Elopement Drill Report dated 11/25/2025 indicated a mock elopement/missing resident drill was conducted at 10:30 a.m., and 18 staff (Regional nurse, 1 Business office, 3 dietary staff, 3 housekeeping/laundry staff, 5 CNAs, 1 MA, 1 LVN, 1 maintenance and 2 therapists) participated. Record review of a Wander/Elopement Drill Report dated 11/25/2025 indicated a mock elopement/missing resident drill was conducted at 4:23 p.m. and 13 staff (3 LVNs, 1 MDS Nurse, 2 MAs, 2 CNAs, 3 dietary staff, 1 business office, and 1 activity director) participated. Some were staff who were not listed on the other drill on 11/25/2025. Record review of a Wander/Elopement Drill Report dated 11/28/2025 indicated a mock elopement/missing resident drill was conducted at 10:00 p.m., and 6 staff (3 LVNs, and 3 CNAs) participated. Some were staff who were not listed on the other drill on 11/25/2025. Record review of the Employee Staff List indicated all staff members had been trained in Elopement prevention and response. Record review of the facility's incident reports from 07/27/2025 through 01/27/2026 indicated there were no elopements. During an interview on 11/27/2026 at 10:45 a.m., LVN G said she had received in-service and participated in elopement drills several times after the elopement. During an interview on 11/27/2026 at 10:49 a.m., LVN D said she had received in-service and participated in elopement drills several times after the elopement. During an interview on 11/27/2026 at 1:45 p.m., HSK J said she had received in-service and participated in elopement drills several times after the elopement. During an interview on 11/27/2026 at 2:00 p.m., CNA L said she had received in-service and participated in elopement drills several times after the elopement. During an interview on 11/27/2026 at 4:00 p.m., CNA M said she had received in-service and participated in elopement drills several times after the elopement. During an interview on 11/27/2026 at 4:15 p.m., LVN B said she had received in-service and participated in elopement drills several times after the elopement. During a phone interview on 1/27/2026 at 8:15 p.m., CNA A said she had received in-service on 03/23/25 and participated in elopement drills several times after the elopement. During interviews on 11/28/2026:* at 9:00 a.m. LVN X said she had received in-service and participated in elopement drills several times after the elopement and was able to verbalize the protocol.* at 10:15 a.m. CNA G said she had received in-service and participated in elopement drills several times after the elopement and was able to verbalize the protocol.* at 11:20 a.m. HSK O said she had received in-service and participated in elopement drills several times after the elopement and was able to verbalize the protocol.* at 11:25 a.m. HSK Q said she had received in-service and participated in elopement drills several times after the elopement and was able to verbalize the protocol.* at 11:31 a.m. CNA P said she had received</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675620	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER Beaumont Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1175 Denton Dr Beaumont, TX 77707	
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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>in-service and participated in elopement drills several times after the elopement and was able to verbalize the protocol.* at 1:45 p.m. MDS Nurse said she had received in-service and participated in elopement drills several times after the elopement and was able to verbalize the protocol.* at 1:41 p.m. DS Y said she had received in-service and participated in elopement drills several times after the elopement and was able to verbalize the protocol.* at 1:45 p.m. DS ZZ said she had only worked at the facility for about a week but received elopement in-service during her orientation and was able to verbalize the protocol.* at 1:50 p.m. DS BB said she had only worked at the facility for about a week but received elopement in-service during her orientation and was able to verbalize the protocol.* at 2:10 p.m. HSK S said he had received in-service and participated in elopement drills several times after the elopement and was able to verbalize the protocol.* at 2:12 p.m. CNA T said she had only worked at the facility for less than a month but received elopement in-service during her orientation and was able to verbalize the protocol.* at 2:15 p.m. CNA U said she had worked at the facility for less than a month but received elopement in-service during her orientation and was able to verbalize the protocol.* at 2:20 p.m. SLP AA said she had received in-service and participated in elopement drills several times after the elopement and was able to verbalize the protocol. She said she did 1:1 monitoring with Resident #1 and was trained to keep resident in direct eye contact and prevent elopement.* at 3:31 p.m. CNA V said she had received in-service and participated in elopement drills several times after the elopement and was able to verbalize the protocol.* at 3:35 p.m. CNA W said she had received in-service and participated in elopement drills several times after the elopement and was able to verbalize the protocol.* at 4:15 p.m. SW said she had received in-service and participated in elopement drills several times after the elopement and was able to verbalize the protocol. On 11/28/2025 at 4:35 p.m., the Administrator was informed of the Immediate Jeopardy. The non-compliance was identified as past non-compliance. The Immediate Jeopardy began on 11/24/2025 and ended on 11/25/2025. The facility had corrected the noncompliance before survey began.</p>		