| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675690 | A. Building<br>B. Wing | 05/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Golden Estates Rehabilitation Center | 130 Spencer LN<br>San Antonio, TX 78201 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consult with the resident's physician and representative when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for 1 of 18 residents (Resident #1) reviewed for resident rights.<br><br>The facility failed to notify Resident #1's physician and representative when the resident was missing on 5/10/25.<br><br>This failure could place residents at risk of not receiving adequate and timely intervention and a decline in condition.<br><br>The findings included:<br><br>Record review of Resident #1's face sheet dated 5/28/25 revealed a [AGE] year-old male admitted to the facility on [DATE] and discharged on 5/10/25 with diagnoses that included unspecified dementia unspecified severity (general term used to describe a decline in cognitive function that is severe enough to interfere with daily life and activities)-without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.<br><br>Record review of Resident #1's MDS discharge assessment dated [DATE] revealed the resident was severely cognitively impaired for daily decision-making skills and was independent with mobility.<br><br>Record review of Resident #1's baseline care plan, undated, was blank.<br><br>Record review of Resident #1's physician's telephone orders, dated 5/8/25 revealed no order for close monitoring of the resident and included the following:<br><br>- Admit to respite for 5-day period from 5/8/25-5/13/25<br><br>Record review of Resident #1's electronic record with the following progress note dated 5/10/25, time stamped 4:18 p.m., and authored by the Administrator revealed: Resident (#1) has been observed with increased wandering throughout the facility. Hospice notified and stated the family had called earlier letting them know they would be back in town around 8:00pm and intended to pick resident up from respite today. Resident (#1) to DC home with all medication and personal belonging 5/10/2025.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of Resident #1's electronic record progress notes from 5/8/25 to 5/10/25 revealed there was no documentation that indicated the resident's representative was notified of the resident's wandering behaviors or that the resident had gone missing.<br><br>During an interview on 5/28/25 at 1:29 p.m., the ADON stated he was notified by RN F Resident #1 was missing and the ADON in turn notified the Administrator on 5/10/25. The ADON stated since the resident was treated by hospice, the hospice staff would have been notified. The ADON stated at the time of the event the Administrator was already in the building and believed the Administrator made notification to the RN Corporate Nurse.<br><br>During an interview on 5/28/25 at 1:49 p.m., the Administrator stated she had received notification from the ADON on 5/10/25 about Resident #1 missing from the facility. The Administrator stated she was about 4 or 5 minutes away but could not remember the exact time. The Administrator stated she notified the hospice company regarding Resident #1's exit seeking behaviors and to my understanding he (Resident #1) went out the front door and told them (the hospice company) we were not equipped to care for Resident #1 and the family came and picked him up. The Administrator stated, I believe I informed Resident #1's representative that the resident was gone and stated she had inform the hospice company. The Administrator stated she did not report the incident to the physician. The Administrator stated, when Resident #1 went missing it was not considered a true elopement because the resident was still on campus and was gone for no more than 4 minutes.<br><br>During an interview on 5/28/25 at 2:17 p.m., RN F stated she was informed by CNA C on 5/10/25 that Resident #1 was missing, and RN F and the staff began to search for the resident. RN F stated, when Resident #1 was found she assessed the resident for injuries and obtained the resident's vital signs. RN F stated during this time the Administrator and the ADON were already in the building and then RN F stated, once the managers (Administrator and ADON) came in, they took over and I then went back to attend to my hall. I was pretty much told to go back to my unit. RN F further stated, she believed the hospice company was notified regarding Resident #1 missing and believed the ADON was going to notify the doctor and the representative. RN F stated, basically, I was told I was a floor nurse and to attend to my patients by the Administrator, and the ADON and she (the Administrator) would take care of the rest.<br><br>During a telephone interview on 5/28/25 at 5:33 p.m., Resident #1's family representative stated she received notification on 5/10/25 about Resident #1 trying to leave the facility. Resident #1's family representative stated, I believe I was told about him (Resident #1) trying to leave the building. It was not the facility; it was the hospice company that called or texted me and told me he (Resident #1) tried to leave the building.<br><br>During an interview on 5/29/25 at 11:32 a.m., LVN H stated in the case of a missing resident/elopement, there was supposed to be notification to the Administrator, DON, ADON, the physician and family representative. LVN H further stated, even if a resident was in the facility under hospice services, the resident was cared for by facility staff daily and the hospice staff was not always in the facility.<br><br>During a follow-up interview on 5/29/25 at 2:31 p.m., the ADON stated, Resident #1's hospice staff was notified on 5/10/25 when the resident was reported missing. The ADON further stated he did not know if the resident's representative or the physician were notified. The ADON stated, the Administrator took over doing the notification part.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a follow-up interview on 5/29/25 at 3:26 p.m., the Administrator stated she had notified the hospice company on 5/10/25 to report Resident #1 was exit seeking and stated the hospice staff would contact Resident #1's representative directly. The Administrator stated, typically she would notify the family in any case, but since hospice was notified, hospice did it for them. The Administrator stated, we should have notified the doctor, but did not. The Administrator stated, the resident's representative, the doctor, and hospice should have been notified by the facility, but the event created chaos and at that moment, and Resident #1 was the priority.<br><br>Record review of the facility document titled Charting and Documentation with review date December 2024 revealed in part, .All services provided to the resident .or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care .The following information is to be documented in the resident medical record . Changes in the resident's condition .Events, incidents or accidents involving the resident .Documentation of procedures and treatments will include care-specific details, including .Notification of family, physician or other staff . |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to develop and implement baseline care plans that included the instructions needed to provide effective and person-centered care within 48 hours of admission for 1 of 1 resident (Resident #1) reviewed for baseline care plans:<br><br>The facility failed to complete Resident #1's baseline care plan within 48 hours.<br><br>This deficient practice could affect residents who receive care at the facility and could result in missed or inadequate care.<br><br>The findings included:<br><br>Record review of Resident #1's face sheet dated 5/28/25 revealed a [AGE] year-old male admitted to the facility on [DATE] and discharged on 5/10/25 with diagnoses that included unspecified dementia unspecified severity (general term used to describe a decline in cognitive function that is severe enough to interfere with daily life and activities)-without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.<br><br>Record review of Resident #1's MDS discharge assessment dated [DATE] revealed the resident was severely cognitively impaired for daily decision-making skill and was independent with mobility and transfers.<br><br>Record review of Resident #1's baseline care plan, undated, was blank.<br><br>Record review of Resident #1's physician's telephone orders, dated 5/8/25 revealed the following:<br><br>- Admit to respite for 5-day period from 5/8/25-5/13/25<br><br>- DNR status: Full code<br><br>- Activity - up as tolerated<br><br>- Diet: Regular<br><br>- Oxygen: O2 at 2L/NC PRN - Has not used<br><br>- No treatments or appliances<br><br>- Meds:<br><br>- Carbidopa-Levodopa 25/100 mg po 1 in a.m., 1 at HS (primarily used to treat symptoms of Parkinson's-tremors, stiffness, poor muscle control)<br><br>- Vitamin D3 1,000U/25 mcg, take 1 tab po QD (primarily used to help the body absorb calcium and maintain strong bones)<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - Nuplazid 34 mg, take 1 po QD (primarily used to treat hallucinations and delusions associated with Parkinson's)<br><br>- Repatha 140 mg/ml, take 1 ml SQ every 2 weeks (used to lower cholesterol)<br><br>- Clonazepam 1 mg tab, take 1 tab at HS (primarily used to treat panic or anxiety disorders)<br><br>- Haloperidol 1 mg tab, take 2 tabs po TID (primarily used to reduce hallucinations, delusions, and disorganized thinking)<br><br>- Isosorbide Mononitrate ER 60 mg tab, take 1 po QD (use to prevent chest pain caused by coronary artery disease)<br><br>- Metoprolol Succinate ER 50 mg, take 1 tab daily (used to treat heart and blood pressure conditions)<br><br>- Morphine Concentrate 20 mg/ml, take 5 mg/.25 ml TID prn SOB, CP (used to treat moderate to severe pain or chest pain)<br><br>- Quetiapine 25 mg, 1 tab twice daily (an antipsychotic medication used to treat several mental health conditions)<br><br>- Hospice nurse may pronounce at time of death<br><br>- Please call hospice with any changes in condition/questions/concerns 24/7 and any med refill needs<br><br>- Please no labs or diagnostics<br><br>Record review of Resident #1's Clinical admission document, dated 5/8/25 revealed the following:<br><br>- Alert and oriented x 3, communicated verbally, speech is clear, is able to understand and be understood when speaking.<br><br>- the Mood and Behavior section, under the Wandering category was blank.<br><br>- the Special Care section used to determine the reason Resident #1 was in the facility (Hospice, Respite Care, Palliative Care, Source of discharge goal) was blank.<br><br>Further review of the 47-page Clinical admission document, under the Care Planning section, page 20 to page 38 were blank.<br><br>During an interview on 5/30/25 at 7:44 a.m., LVN M stated she had taken part in doing an admission assessment on new resident admissions, but I don't do the care plan part. I think the MDS (Coordinator) from what I know generates the care plan.<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 5/30/25 at 8:20 a.m., LVN H stated she had taken part in doing an admission assessment on new resident admissions and the admission assessment document should automatically generate a baseline care plan. LVN H stated the baseline care plan should be done within 24 hours from the residents' admission and should include medical diagnoses, clinical information received based on past history and any specifics about the resident's care and how they take their medications.<br><br>During an interview on 5/30/25 at 9:31 a.m., the MDS Coordinator stated the baseline care plan would be completed within 72 hours but should start on admission. The MDS Coordinator stated the baseline care plan was supposed to have a minimized assessment of the resident's basic needs such as mobility status, incontinence, skin issues, and all of your assessments. The MDS Coordinator stated Resident #1's baseline care plan was incomplete and should have been generated at the time of his admission. The MDS Coordinator stated, the assessment did not give a whole picture of Resident #1, and that did not help when trying to develop a comprehensive care plan and the MDS assessment.<br><br>During an interview on 5/30/25 at 9:59 a.m., RN P stated she had initiated the admission assessment for Resident #1 when he admitted on [DATE]. RN P stated the admission assessment did not automatically generate a baseline care plan. RN P stated she did not know anything about a baseline care plan and stated the MDS Coordinator does those. RN P stated she was not involved in the process in the development of a comprehensive care plan, we just do the documentation.<br><br>During an interview on 5/30/25 at 12:54 p.m., the ADON stated he was unsure of when a baseline care plan needed to be developed or the time frame for completion. The ADON stated the care plan was important because it identified behaviors, how to assist them (residents) with care, and how to attend to their needs.<br><br>During an interview on 5/30/25 at 3:07 p.m., the RN Corporate Nurse stated the admission assessment done during a resident's admission into the facility would trigger, sometimes depending on how the questions were answered by the nurse. The RN Corporate Nurse stated, as an example, if a box was checked on the admission assessment for a resident who utilized an indwelling urinary catheter, the assessment would trigger and generate suggestions at the end of the assessment and would push it to the care plan. The RN Corporate Nurse stated, she believed the baseline care plan, per regulation, had to be completed within 48 hours and the information from the moment you meet the resident, your assessment is for building the care plan. The RN Corporate Nurse stated the care plan was used to assist the staff in knowing how to care for a resident.<br><br>Record review of the facility document titled, Charting and Documentation with review date December 2024 revealed in part, .All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care .The following information is to be documented in the resident medical record .Progress toward or changes in the care plan goals and objectives . Documentation of procedures and treatments will include care-specific details . |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents for 1 of 1 resident (Residents #1) reviewed for accidents hazards and supervision:<br><br>The facility failed to put effective measures in place to prevent Resident #1 from eloping. Resident #1 was found outside the facility near the access road near the expressway on Saturday, 5/10/25. The facility did not have a plan in place for monitoring the front door to ensure resident supervision/monitoring was in place to prevent Resident #1's elopement.<br><br>An IJ was identified on 5/28/25. The IJ template was provided to the facility on 5/28/25 at 5:04 p.m. While the IJ was removed on 5/30/25, the facility remained out of compliance at a scope of isolated and a severity level of not actual harm with potential for more than minimal harm that is not immediate jeopardy because the facility needed to evaluate the effectiveness of its corrective systems<br><br>This failure could place residents at risk of experiencing accidents, injuries, and/or death.<br><br>The findings included:<br><br>Record review of Resident #1's face sheet dated 5/28/25 revealed a [AGE] year-old male admitted to the facility on [DATE] and discharged on 5/10/25 with diagnoses that included unspecified dementia unspecified severity (general term used to describe a decline in cognitive function that is severe enough to interfere with daily life and activities)-without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.<br><br>Record review of Resident #1's MDS discharge assessment dated [DATE] revealed the resident was severely cognitively impaired for daily decision-making skills and was independent with mobility. Resident #1's MDS did not indicate any behaviors.<br><br>Record review of Resident #1's baseline care plan, undated, was blank.<br><br>Record review of Resident #1's physician's telephone orders, dated 5/8/25 revealed to admit to respite for 5-day period from 5/8/25-5/13/25. There was no order for monitoring the resident.<br><br>Record review of Resident #1's Clinical admission document, dated 5/8/25 revealed the resident was:<br><br>- Alert and oriented x 3, communicated verbally, speech is clear, is able to understand and be understood when speaking.<br><br>Further review revealed the following areas were left blank:<br><br>- the Mood and Behavior section, under the Wandering category<br><br>- the Special Care section used to determine the reason Resident #1 was in the facility (Hospice, Respite Care, Palliative Care, Source of discharge goal)<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | - the Care Planning section, page 20 to page 38<br><br>Record review of Resident #1's admission Function Abilities and Goals document, dated 5/8/25 revealed he had no functional limitations in range of motion, was independent with mobility, and did not require a mobility device.<br><br>Record review of Resident #1's progress note dated 5/10/25, time stamped 4:18 p.m., and authored by the Administrator revealed: Resident (#1) has been observed with increased wandering throughout the facility. Hospice notified and stated the family had called earlier letting them know they would be back in town around 8:00pm and intended to pick resident up from respite today. Resident (#1) to DC home with all medication and personal belonging 5/10/2025.<br><br>Record review of the facility Incidents/Accidents reports reviewed from March 2025 to May 2025 revealed there was no incident report regarding Resident #1's wandering/elopement.<br><br>Observation on 5/28/25 at 8:15 a.m. revealed the front door to the facility was unlocked, no code was needed to enter the front door, and the front receptionist desk was unattended.<br><br>During an interview on 5/28/25 at 10:05 a.m., the Activities Director stated she was familiar with Resident #1 and described the resident as very confused but easily re-directable. The Activities Director stated the front door to the facility had a day mode sound that triggered when the door opened and there was a receptionist scheduled day and night. The Activities Director stated, if the receptionist was not stationed at the front desk, the Executive Assistant would be able to see the desk from the glass door in the office.<br><br>During a telephone interview on 5/28/25 at 10:33 a.m., Resident #1's family member stated the resident stayed at the facility for two nights and had never stayed there before. The family member further stated Resident #1 returned home (5/10/25) at baseline and did not have any concerns with the care except the facility could not find the residents clothes or shoes. The family member stated Resident #1 had further declined since the resident admitted to the facility on [DATE] and was not talking too much these days and was not interviewable. Resident #1's family representative stated she received notification on 5/10/25 about Resident #1 trying to leave the facility. Resident #1's family representative stated, I believe I was told about him (Resident #1) trying to leave the building. It was not the facility; it was the hospice company that called or texted me and told me he (Resident #1) tried to leave the building.<br><br>(continued on next page) |

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|---|---|
| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 5/28/25 at 10:49 a.m., CNA A stated she recalled Resident #1 leaving the building on a weekend, maybe a Saturday at the end of the shift, some time before 2:30 p.m. CNA A stated the code (Code Pink) was announced by an unidentified nurse and CNA B told her to start searching all the rooms. CNA A stated she and CNA C searched together and further stated CNA C was assigned on the hall Resident #1 resided on. CNA A stated two unidentified staff went driving looking for the resident. CNA A stated Resident #1 was found across the street by the highway and an unidentified staff stated, he's (Resident #1) there by the expressway. CNA A stated, CNA D and CNA B escorted Resident #1 back to the facility. CNA A stated she believed the event may have occurred between 1:00 p.m. and 2:00 p.m. CNA A stated she recalled an unidentified receptionist was on duty at the time. CNA A stated, there were times the receptionist would leave the reception area to deliver packages to the residents or to deliver messages to residents. CNA A stated, I'm sure the alarm was on when Resident #1 left, they are always on. It happened quickly. I'm glad we found him, but he made it across the street. CNA A stated Resident #1 was asked where he was going and said he was going home and had gone out the back door. CNA A stated the back door was locked and all of the doors have alarms and believed the alarms to all of the doors were working.<br><br>During an interview on 5/28/25 at 11:12 a.m., CNA C stated she was assigned on Resident #1's hall and described the resident as confused. CNA C stated she recalled Resident #1 had left the facility and recalled assisting the resident with his meal while the resident was in his room on the day of the event. CNA C stated she picked up Resident #1's food tray after assisting him, could not recall the time, and could not recall if it was breakfast or lunch, and left the resident in his room. CNA C stated she returned to Resident #1's room, less than 15 minutes later, and the resident was gone. CNA C stated she asked staff if they had seen the resident, and CNA E told her Resident #1 was seen walking around the hallways. CNA C stated she continued her search and when she could not locate the resident she informed the nurses. CNA C stated, an unidentified nurse said Resident #1 was outside but could not recall where the resident was found. CNA C stated CNA D brought the resident back into the facility. CNA C further stated, I know some staff walked around to try to find him (Resident #1) outside and people drove in their cars to try to find him. CNA C then stated she believed the event happened after lunch. CNA C stated she believed the door alarms were working at the time and asked the receptionist, could not recall the name, if she had seen Resident #1 leave and the Receptionist said no.<br><br>During an interview on 5/28/25 at 11:38 a.m., CNA E stated she was in the facility when it was reported Resident #1 went missing. CNA E stated she believed the event happened around lunchtime and was asked by CNA C if she had seen Resident #1. CNA E stated she saw Resident #1 across the street by the barricade that led to the highway. CNA C stated Resident #1 had crossed the access road and was brought back to the facility by CNA D. CNA E stated the Weekend Receptionist, name unknown, stepped away to go to the bathroom, and I guess that's when he (Resident #1) got out. CNA E further stated all the doors were locked and if you try to open them the alarm goes off. CNA E stated she believed Resident #1 went out the front door.<br><br>During an interview on 5/28/25 at 1:29 p.m., the ADON stated RN F notified him Resident #1 was missing and the ADON in turn notified the Administrator. The ADON stated he arrived at the facility between 2:15 p. m. and 2:30 p.m. and Resident #1 was already at the nurse's station. The ADON stated RN F called the Code Pink, which indicated a resident was missing, and was told Resident #1 was found up front. The ADON stated all of the doors have alarms on them.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 5/28/25 at 1:49 p.m., the Administrator stated she was notified by the ADON about Resident #1 missing but could not recall what time she received the message. The Administrator stated she was approximately 4 to 5 minutes away from the facility and when she arrived Resident #1 was already at the nurse's station getting assessed by RN F. The Administrator stated she was told by RN F that the resident was found at the front of the building. The Administrator then stated, Resident #1 was gone for no more than 4 minutes.<br><br>During a telephone interview on 5/28/25 at 2:17 p.m., RN F acknowledged she was informed by an unknown CNA that Resident #1 was not in his room and asked the CNA when she had seen the resident last. RN F stated the CNA told her about 5 - 10 minutes ago. RN F stated she had staff start a search and an unidentified CNA she described as a tall, thin African American male who worked the 2:00 p.m. to 10:00 p.m. shift found Resident #1 in the front of the building. RN F stated the Administrator and the ADON were in the building at the time she assessed Resident #1. RN F stated she believed the event occurred after lunch, before my 4:00 p.m. scheduled accu checks.<br><br>During an interview on 5/28/25 at 3:01 p.m., CNA D stated he was about to start his shift, which began at 2:30 p.m. and was approached by an unknown nurse who informed him they were looking for a patient. CNA D stated he and CNA B went outside the front door and found Resident #1 in the parking lot in an area with bushes just inside the street. CNA D stated he was familiar with Resident #1 and described him as not really alert, not aware, and always looked lost.<br><br>During an interview on 5/28/25 at 3:20 p.m., CNA B stated she heard an unidentified CNA saying somebody was missing on the day of the event at approximately 1:30 pm to 2:00 p.m. CNA B stated she was approaching the end of her shift at 2:30 p.m., when she and CNA D retrieved Resident #1 where the resident was found in the parking lot by the bushes. CNA B stated the resident appeared confused.<br><br>During an interview on 5/28/25 at 3:40 p.m., the Maintenance Director stated he did random rounds of the door alarms and further stated he had installed additional alarms on the 100 and 200 unit. The Maintenance Director stated he was not sure when the door alarm for the front door was activated as there was a daytime mode and a nighttime mode.<br><br>During a telephone interview on 5/28/25 at 4:24 p.m., LVN G acknowledged she recalled the event that occurred when Resident #1 went missing. LVN G stated, after it was determined Resident #1 was missing, LVN G went next door to the local gas station to search for the resident. LVN G stated she then spotted Resident #1 by the grass, not in the street, and the tall, African American male CNA went to get the resident. LVN G stated she had only worked for the facility for close to a month, the event happened so fast, and did not know about the alarm system.<br><br>During a follow-up telephone interview on 5/28/25 at 5:33 p.m., Resident #1's family member stated the resident's hospice representative informed her about Resident #1 attempting to leave the facility. Resident #1's family member stated she was never told Resident #1 made it outside the facility. Resident #1's family member stated she could not always believe what Resident #1 said and stated the resident had significantly declined since his discharge from the facility on 5/10/25 and was no longer interviewable. Resident #1's family member stated, at the time the resident was discharged , and when she picked him up, Resident #1 told her he had gone out the back door and then went to the highway and was picked up. Resident #1's family member stated, there's no way he (Resident #1) could have gone to the highway, he would have been killed. I didn't question the facility about it.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 5/30/25 at 8:20 a.m., LVN H stated there was always a staff sitting at the receptionist desk during business hours. LVN H stated there was a receptionist at the front entry until 10:30 p.m. but the doors were locked after 5:00 p.m., and then the receptionist would have to get up and open the door. LVN H stated the Maintenance Director was in charge of checking the door alarms and if there was a problem with an alarm not working, the Maintenance Director would have to be notified. LVN H stated, if the receptionist who worked during their scheduled hours had to leave their post, we have somebody watch the doors for them until they return. LVN H stated the front reception area was not supposed to be left unattended.<br><br>During an interview on 5/30/25 at 8:40 a.m., the Floor Technician stated there was supposed to be a person at the front reception desk at all times and they have somebody come in during the evening up until 10:30 p. m. The Floor Technician stated he sometimes checked the door alarms, but when there was a problem, he would report it to the Maintenance Director. The Floor Technician stated, when the doors were locked, the door alarm goes off if somebody was trying to leave or get in.<br><br>An attempt at a telephone interview on 5/30/25 at 3:16 p.m., with Receptionist I was unsuccessful; the voicemail box was full and was unable to leave a message.<br><br>During an interview on 5/30/25 at 3:31 p.m., the Executive Assistant stated she monitored the front door as part of her duties. The Executive Assistant stated she had other job duties, and if she was unable to monitor the front door, she would get somebody to cover the front door. The Executive Assistant stated she usually arrived at the facility between 6:30 a.m., and 6:45 a.m., and the doors were usually unlocked. The Executive Assistant stated she could monitor the front door from her desk until Receptionist clocked in at 4:00 p.m. The Executive Assistant stated the Receptionist worked until about 10:30 p.m., or 11:00 p.m., but the doors were locked at 5:00 p.m. The Executive Director stated if the front door alarm did not engage when it was opened, then the Maintenance Director had to be notified.<br><br>During an interview on 5/30/25 at 3:52 p.m., the Weekend Receptionist stated she often worked the weekends from 11:00 a.m. to 11:00 p.m. and the Manager on Duty covered monitoring of the front door until she arrived at her shift. The Weekend Receptionist stated, if she had to leave her post, such as to take a bathroom break, she would go really quick, but I can still hear the door/chime/ringer. The Weekend Receptionist stated it was the responsibility of the Maintenance Director to ensure the door alarms were working. The Weekend Receptionist did not have recollection of the event when Resident #1 went missing.<br><br>During an interview on 5/30/25 at 4:41 p.m., Receptionist J stated she worked the evening shift from 4:00 p. m. to 10:30 p.m., and the front doors were locked at 5:00 p.m. Receptionist J stated the front door had a ring/chime that activated each time the door was opened. Receptionist J stated if she had to leave her post, she had to get somebody to cover for her. Receptionist J stated she had to report to nursing at the end of her shift to inform them she was leaving, and the doors stayed locked.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review of the facility document titled, Safety and Supervision of Residents, with revision date December 2007 revealed in part, .Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities . Our facility-oriented approach to safety addresses risks for groups of residents .Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes .Employees shall be trained and inserviced on potential hazards and how to identify and report accident hazards, and try to prevent avoidable accidents .Staff shall use various sources to identify risk factors for residents, including the information obtained from the medical history, physical exam, observation of the resident, and the MDS .Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment .Resident Risks and Environmental Hazards .Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include .Unsafe Wandering .<br><br>Record review of the facility document titled, Wandering, Resident, undated, revealed in part, .The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement .The staff will identify residents who are at risk for harm because of unsafe wandering (including elopement) .A missing resident is considered a facility-wide emergency. If a resident is missing, the elopement/missing resident emergency procedure will be initiated .If the resident is not located, notify the Administrator, and the Director of Nursing Services, the resident's legal representative, the Attending Physician, law enforcement officials .When the resident returns to the facility, the Director of Nursing Services or Charge Nurse shall .Contact the Attending Physician and report findings and conditions of the resident .Complete and file an incident report .<br><br>An Immediate Jeopardy was identified on 5/28/25 and the Administrator was notified of the Immediate Jeopardy on 5/28/25 at 5:04 p.m. and was given a copy of the IJ template and a Plan of Removal (POR) was requested.<br><br>The facility's Plan of Removal for the Immediate Jeopardy was accepted on 5/29/25 at 4:12 p.m. and reflected the following:<br><br>Nursing Facility F689 - Free of Accident Hazards/Supervision Devices<br><br>- Resident (#1) was immediately placed on 1:1 (5/10/2025)<br><br>- Hospice company notified of resident (#1) exit seeking (5/10/2025)<br><br>- Resident had scheduled discharge planned (5/10/2025)<br><br>- Medical Director Notified (5/28/2025)<br><br>- Elopement assessments completed on all residents residing in facility (5/28/2025)<br><br>- Any resident that scores at risk of elopement will be further evaluated to determine risk level for actual elopement.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | - The facility elopement policy was reviewed with all staff (5/28/2025)<br><br>Actions to Prevent Occurrence/Reoccurrence: The Facility took the following actions to prevent an adverse outcome from reoccurring.<br><br>- Facility exit points checked. (5/10/2025)<br><br>- Front door monitoring is assigned to HR manager from 8:00am to 5:00pm and by the night receptionist from 4:00pm - 10:30pm on weekdays and on weekends by the manager on duty from 7:00am - 11:00am and then by the receptionist from 11:00am - 10:30pm. Door is alarmed to ring at various locations after 10:30pm to alert staff is [sic] someone is attempting to exit the facility.<br><br>- Administrator ordered (2) door alarms to be added to two exit doors. One for a side exit door, and one for the back service exit. (5/13/2025) door alarms arrived and installed in facility (5/14/2025)<br><br>- Maintenance Director checked all door alarms to ensure working condition (5/15/2025)<br><br>- In the event of an elopement the facility will follow our elopement policy.<br><br>- The Administrator or designee is responsible for ensuring the elopement policy education is being provided to all staff members and for providing oversight to ensure it is followed. In-servicing on policy on elopement to continue monthly for 3 months.<br><br>- Beginning 5/28/2025 door alarm checks will be completed 3x per day per shift for 2 weeks.<br><br>- Staff members responsible for front door monitoring were in serviced on ensuring front door monitoring goes uninterrupted, how to redirect residents and calling for help when needed.<br><br>- An elopement in service was initiated within our learning management system and assigned to all staff members. This educational material includes our policy and procedure for an elopement to include a pre and posttest. (5/28/2025)<br><br>- The admission process in service was initiated within our learning management system and assigned to all licensed nursing staff to include completing an elopement assessment and a baseline care plan.<br><br>- Staff will acknowledge residents who are at risk of elopement by checking off the POC alert created.<br><br>- Careplans were reviewed and updated for residents deemed to be at risk of elopement. (5/28/2025)<br><br>The facility's POR Verification was as follows:<br><br>Record review of the POR binder included:<br><br>- Door alarm receipt of purchase dated 5/13/25<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | - Bell alarm receipt of purchase dated 5/29/25<br><br>- MD notification letter informing the physician of the IJ deficiency related to an elopement authored by the Administrator and dated 5/28/25<br><br>- Communication record of voicemail/text to families regarding signing out residents dated 5/28/25<br><br>- Elopement assessments and care plan updates of 65 residents completed by the ADON, MDS nurse and LVN Treatment Nurse K dated 5/28/25<br><br>-Management of the security of the front door in-service training of 16 department head staff presented by the Administrator/Designee with start date 5/29/25 and ongoing until completed<br><br>- Elopement training records of 74 staff with completion dates from 5/28/25-5/30/25<br><br>- Incident/Accidents Training records of 48 staff with completion dates ranging from 3/25/25-5/29/25<br><br>- Registration Document for Staff Training indicating there were 79 staff registered to take the training on Elopement dated 5/30/25<br><br>Record review of the in-service titled Management of the security of the front door, dated 5/29/25 listed the following objectives:<br><br>1) The front door needs to be monitored at all times, if you need to leave the front reception or office area you must find someone to relieve you.<br><br>2) If any situation occurs calls for assistance via overhead paging or directly to the nurse's station.<br><br>3) Training on how to redirect residents who may express a desire to exit the facility.<br><br>Interviews conducted on 5/30/25 from 7:29 a.m. to 4:46 p.m. with 31 staff from various shifts (LVN L, Director of Staff Development, LVN M, CNA N, LVN H, Floor Technician, Medical Records, RN Instructor, Housekeeping, CNA O, MDS Coordinator, RN P, CNA Q, Medication Aide R, Maintenance Director, CNA S, CNA D, ADON, RN Corporate Nurse (acting as interim DON), Executive Assistant, Weekend Receptionist, CNA T, Medication Aide U, LVN V, LVN W, CNA X, RN Y, Dietary Z, Receptionist J, Night Shift Cook, and the Dietary Supervisor) revealed facility staff stated they had been in-serviced on front door monitoring to ensure monitoring was uninterrupted, how to re-direct residents, how to call for help when needed, and how to follow the elopement policy which included educational training material with a pre and posttest.<br><br>Record review of the in-service materials including the pre and posttest provided by the RN Corporate Nurse revealed training on identification of residents at risk of elopement, the process for continuity of assessments for those residents at risk of elopement, and a guideline to search for a resident who was missing or had eloped.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review of the POR binder revealed the management of the security of the front door in-service training was signed by 16 department head staff and presented by the Administrator with start date 5/29/25.<br><br>During an interview on 5/30/25 at 3:07 p.m., the RN Corporate Nurse stated she had created the in-service training materials and had assisted with in-service training. The RN Corporate Nurse stated there should be notification to the family, the physician, and the Administrator in the case of an elopement and the staff were supposed to follow the Code Pink protocol for a missing resident.<br><br>During an observation with the Maintenance Director on 5/30/25 at 3:20 p.m. revealed all facility exit doors including the front door and all doors on the 100/200/300 Resident hallways alarms were tested for working efficiency with no concerns noted. Observation of the outside property gates for security locks were observed in place.<br><br>During an interview on 5/30/25 at 5:30 p.m., the Administrator stated there were 79 staff employed at the facility and 77 out of 79 completed the Elopement training. The Administrator stated the two staff who did not complete the Elopement training was a new hire who had not yet started working on the floor and the other staff was out on emergency leave and could not be contacted. The Administrator stated the two staff who had not completed the Elopement training would be in-serviced prior to working on the floor. The Administrator further stated in-service training for completing incident/accident reports were completed with licensed nursing staff.<br><br>On 5/30/25 at 5:41 p.m., the Administrator was notified the IJ was removed. While the IJ was removed on 5/30/25, the facility remained out of compliance at a scope of isolated and a severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy because of the facility's need to evaluate the effectiveness of its corrective systems. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles for 1 of 2 nurse medication carts (Unit 1 medication cart)reviewed for storage of drugs and biologicals.<br><br>The facility failed to ensure the Unit 1 medication cart was locked and secured when Medication Aide U left a medication cart unlocked and unsecured on 5/29/2025.<br><br>This failure could place residents at risk of medication misuse or drug diversion.<br><br>The findings included:<br><br>Observation and interview on 5/29/25 at 12:56 p.m. revealed the Station 1 medication cart was left unlocked and unattended in front of the Station 1 nurse's station, facing out into the main pathway where 6 residents were observed sitting in wheelchairs in front of the medication cart. Further observation revealed LVN AA was sitting behind the Station 1 nurse's station. LVN AA stated the medication cart was assigned to Medication Aide U. The Administrator walked up to LVN AA and the State Surveyor and stated the medication cart in Station 1 was assigned to Medication Aide U.<br><br>During an observation and interview on 5/29/25 at 12:58 p.m., Medication Aide U stated the Station 1 medication cart assigned to her was unlocked and unattended and believed she had locked the medication cart, but the lock must have popped open. Medication Aide U stated the medication cart was not supposed to be left unlocked and unattended because residents can get into it, or other people can get into it and take things. Medication Aide U further stated, only facility staff should have access to the medication cart and only she would have access to the cart since she had the key.<br><br>During an interview on 5/29/25 at 2:31 p.m., the ADON stated, the medication carts were supposed to be locked when left unattended because somebody can have access to the medications, including the residents. The ADON further stated, residents could take the wrong medication and could overdose.<br><br>During an interview on 5/30/25 at 3:07 p.m., the RN Corporate Nurse stated, the medication carts were supposed to remain locked and if unlocked and unattended somebody could open a medication, they could take a medication and they could become ill from it. The RN Corporate Nurse stated it was her expectation that all medication carts were secure when not in use.<br><br>Record review of the facility document titled Security of Medication Cart with review date December 2024 revealed in part, .Medication carts must be securely locked at all times when out of the nurse's view .When the medication cart is not being used, it must be locked and parked at the nurse's station or inside the medication room . |