STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675810	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lancaster Ltc Partners Inc	1515 N Elm St Lancaster, TX 75134

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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 - Some	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** 15315 Based on observations, interviews, and record review, the facility failed to ensure each resident received adequate supervision and that the resident's environment remained as free of accident hazards as possible for one (Resident #1) of five residents reviewed for elopement on the facility's secured unit. The facility failed to adequately supervise, monitor, and implement interventions to prevent Resident #1 (who was assessed with severe cognitive impairment and as being at risk for elopement) from eloping from the facility unsupervised on [DATE] where he remained unaccounted for overnight. The resident was located on [DATE], 2.6 miles from the facility. The facility failed to ensure the door to the secure unit was properly functioning as the door did not fully close and/or lock consistently. On [DATE] at 5:25 p.m. an Immediate Jeopardy was identified. While the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at a severity level of potential for more than minimal harm that is not immediate jeopardy and at a scope of pattern due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. This failure could place residents at risk for injury and/or death from elopement-related harm, including vehicular accidents, falls, missing medications, and extreme weather exposure. Findings included: Review of Resident #1's active physician orders dated [DATE] revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1's diagnoses included cocaine abuse, intracerebral hemorrhage (type of stroke, interruption of blood flow to a part of the brain either by a blockage or rupture of a blood vessel) and encephalopathy (encephalopathy-a group of conditions that cause brain dysfunction. Brain dysfunction can appear as confusion, memory loss, personality changes, and/or coma in the most severe form). Review of Resident #1's quarterly MDS assessment, dated [DATE], revealed he was ambulatory without the use of a device, required supervision and/or physical assistance with hygiene, dressing, and toileting. The MDS assessment reflected the resident's BIMS score was a 3 indicating severe cognitive impairment. (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's care plan with a review date of [DATE] revealed the resident's risk for elopement due to poor safety awareness was addressed. Goals included the resident would not leave the facility or the property unattended. The only intervention was to house the resident on the secured unit for safety. The care plan addressed the resident's elopement on [DATE] but did not include any additional interventions. Review of Resident #1's current Elopement Risk Assessments dated [DATE] and [DATE] reflected the resident had been assessed to be at risk for elopement. Observation on [DATE] at 11:20 a.m. of the secured unit entrance door located on Hall 200 revealed no code was required for entry. Entrance only required pressing the crash bar on the door. A code was required to exit and there was no alarm on the door. In an interview on [DATE] at 2:45 p.m. the Administrator stated Resident #1 exited the secured unit and eloped from the facility on the evening of [DATE]. She stated she was notified at approximately 10:00 p.m. on [DATE] that the resident was missing. The police were notified, and staff searched inside, outside the facility, and the surrounding neighborhood. The search continued through the morning of [DATE] and the resident was located at approximately 11:00 a.m. on [DATE], 2.6 miles from the facility. Resident #1 was assessed and evaluated at the hospital without injury. The Administrator stated the resident possibly exited the secured unit as staff were entering or leaving the unit without closing the door. The Administrator stated the crash bar on the door to the secured unit that leads to Hall 200 had been previously checked and according to the installer the door was functioning properly. She further stated staff had to make sure the door closed and locked when exiting and entering the secured unit. In an interview on [DATE] at 3:30 p.m. LVN A stated he was the charge nurse on duty during the evening shift on [DATE] when Resident #1 eloped from the facility. He stated he last saw the resident at approximately 6:30 p.m. sitting in the secured unit dining room. LVN A stated he went to pass medications to residents residing outside the secured unit on Hall 200 at approximately 6:00 p.m. After he completed his medication pass, he went outside for a 15-minute break and returned to the unit. He stated at the time he took his break he could not say who remained on the secured unit to supervise the residents. He stated when he heard the alarm (unable to recall what time) he did not know what the sound was and was not going to leave the residents on the unit as the evening CNA (CNA G) was late and had not arrived yet. When the evening CNA arrived (unable to recall what time) she told him the alarm was a door alarm. He confirmed he did not go check to see what door was alarming but provided no explanation when asked why he did not go check. LVN A stated he noticed Resident #1 was missing sometime around 8:00 p.m. or 9:00 p.m. The staff searched the inside and outside of the facility. After staff were unable to locate Resident #1, he called the code for missing resident (code purple) and notified the DON. All staff began searching all areas in the facility. LVN A stated while he was providing care on Hall 200 outside the secured unit it was possible that someone could have entered and/or exited the unit and not ensured the door fully closed and locked. He further stated there was no issue with the secured unit door when exiting, but when entering the secured unit from Hall 200 there was a problem with the crash bar and the door did not always automatically close or lock. He stated everyone in the facility was aware of the problem with the door to include administrative staff. LVN A stated there should always be someone on the secured unit at all times, but he had to take care of residents on Hall 200. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on [DATE] at 10:18 a.m. LVN B stated she had worked at the facility since ,d+[DATE] and the door to the secured unit had always had problems of not closing and locking. She stated at times the door would close and lock and at times it would not. LVN A stated staff had to be sure to physically close the door and ensure it locked. LVN A stated two men had repaired the door earlier in the day. Observation on [DATE] at 10:26 a.m. a visitor entered the secured unit to speak with the charge nurse (LVN B). When the visitor exited the door, the door remained ajar and unlocked. The nurse immediately closed the door and the lock engaged. Observation revealed the door was still not functioning properly. Observation on [DATE] at 10:29 a.m. the DON entered the secured unit to speak with the charge nurse, LVN B. The DON left the unit without the nurse reporting that the door was still not functioning properly. In an interview on [DATE] at 10:33 a.m. LVN C was queried about how long the door to the secured unit had not been closing and locking. She stated the door had not closed and locked properly since it had been installed last year. She stated all staff were aware of the problem with the door and had reported the problem to the Administrator. LVN C further stated the Administrator told staff to always check to ensure the door closed and locked. In an interview on [DATE] at 10:38 a.m. LVN E, the charge nurse for Hall 100, stated she occasionally worked the secured unit. She was aware that sometimes the door to enter the secured unit from Hall 200 would not always fully close or lock. She stated she made sure to check the door when entering/exiting and pulled or pushed the door to ensure it closed all the way. She stated she never reported the problem with the door to the administrative staff but had informed the unit charge nurses in the past. LVN E was unable to recall when or what charge nurse she reported the problem to. In an interview on [DATE] at 10:45 a.m. CNA D stated she had worked at the facility for four days. She stated she was told by facility staff to check to ensure the door to the secured unit closed and locked. She stated she noticed the door would at times bounce back and not fully close or lock. She further stated she did not report the door because all staff seemed to be aware and had told her about the door. Review of staff training records dated [DATE] and [DATE] provided by the Administrator on [DATE]. The records reflected staff received training related to the facility's elopement policy/procedure to include what to do when a resident was missing, observed attempting to leave the facility, and what to do when a missing resident returned to the facility. The training addressed reporting, assessments, and care planning for elopement risk. Review of staff training records dated [DATE] and an undated training record revealed staff received training related to the secure unit doors remaining closed and locked at all times. Training records dated [DATE] reflected topics included the secured unit, but no information related to what was included in the training. Review of training records dated [DATE], [DATE], and [DATE] revealed the procedure for responding to door alarms was addressed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on [DATE] at 11:54 a.m. the Administrator stated she had no in-service training related to the secure unit door not closing or locking consistently. She stated she had not been informed of any problems with the door. She further stated the facility's contractor was last in the building [DATE] and he had checked several things in the facility including the door to the secured unit and it was Ok. When queried about why the contractor had checked the secured unit door, she stated the contractor was in the facility to conduct warranty checks and randomly checked other things in the facility. The Administrator stated she made rounds in the facility and had never seen any problems with the door. In an interview with the Environmental/Maintenance Supervisor on [DATE] at 12:04 p.m. revealed he had worked at the facility for approximately one month. He stated the facility's contractor visited the facility in [DATE], adjusted the latch and the tension of the closer on the secured unit door to help the door close and lock. He stated in the past several nurses and CNAs had reported to him that the door did not always close and lock properly. He stated he reported the issue to the Administrator, and the Administrator contacted the contractor. He stated there had been no other reports related to problems with the door and he had not seen any problems with the door. Review of current maintenance logs revealed they were dated from [DATE] to [DATE]. There was nothing listed in the logs related to the secured unit door. In an interview with the Environmental/Maintenance Supervisor on [DATE] at 12:28 p.m. revealed there were no additional maintenance logs other than what was provided ([DATE]-[DATE]). He stated he performed no routine checks of the secured unit doors. He only made note of issues when he saw an issue on the secured unit. In an interview on [DATE] at 12:32 p.m. CNA F stated she was on duty during the evening of [DATE] when Resident #1 eloped. She stated she was assigned to Hall 200 and arrived to work at approximately 6:30 p.m. When she entered the facility through the side door on Hall 100, she could hear an alarm sounding very low. When she entered the secured unit, the sound was louder but did not last long so she thought someone must had turned the alarm off. The charge nurse was at the desk (LVN A) on the secured unit, and she proceeded to take residents out to the patio for their 15-miunte smoke break. She stated alarms sounded in the facility often at random times. When queried about checking on the alarm she stated she thought the charge nurse (LVN A) would check on the alarm. She stated staff had reported to the charge nurses and to the Administrator multiple times that the door to the secured unit did not always close or lock and the door had been that way since she began working at the facility one year ago. CNA F further stated there were times when visitors and other residents entered the secured unit without checking to ensure the door closed and locked behind them. Observation rounds on the secured unit with Region 3 LSC Program Manager revealed the following: At 12:45 p.m. when the crash bar on the secured unit door was pushed the door opened, closed, and locked without difficulty. At 12:56 p.m. facility staff were entering and exiting the secured unit. Staff physically pushed and pulled with force to ensure the door closed and the lock engaged behind them. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 1:05 p.m. the LSC Program Manager informed the Administrator that the door to the secured unit should close and lock all the time and staff should not have to turn around and physically close the door. In an interview on [DATE] at 3:00 p.m. CNA G stated she worked the evening shift on [DATE] when Resident #1 eloped. She stated she had worked at the facility for one week and [DATE] was the first time she had worked on the secured unit. CNA G stated she arrived to work late at approximately 8:00 p.m. and was informed by staff that Resident #1 had possibly eloped. Staff searched all over the facility to include inside and outside. She stated some staff drove around in their cars searching for the resident. During the evening of [DATE] she saw one of the residents on the secured unit going towards the secured unit door and noticed the door was partially open. She stated she redirected the resident and closed the door. She stated she phoned the Maintenance Supervisor, told him about the door and he came to the facility. The Maintenance Director told her he had to contact the company that installed the door. She did not know how long the door had not been closing and locking. In an interview on [DATE] at 3:19 p.m. CNA H stated she had worked at the facility for three days and the only time she had worked on the secured unit was during the day shift (6:00 a.m. to 6:00 p.m.) on [DATE]. She stated she left the faciity on [DATE] at approximately 6:02 p.m. and Resident #1 was sitting in the day area. She further stated no one was on the unit with the residents when she left but as she was leaving the charge nurse (LVN A) was coming inside the facility through the front door. CNA H further stated the door to the secured unit did not always close and lock. She never reported the problem with the door to anyone because all staff were aware and had told her about the door. When queried about leaving the residents on the unit unsupervised, CNA H stated she did not feel comfortable but had to leave. She stated if she had not seen the nurse coming inside, she would have gone back to the unit. CNA H stated she did not know if the nurse went directly back to the unit. In an interview on [DATE] at 3:58 p.m. Staff I stated she was the OTA and had worked in the facility since February 2024. She stated she was working in the therapy gym on the evening of [DATE] when Resident #1 eloped. She stated she heard the door alarm sounding sometime after 6:30 p.m. but before 7:15 p.m. and the alarm had been sounding for approximately ,d+[DATE] minutes. She stated she was busy at the time but as soon as she could she went to the side door near the therapy gym where the door alarm was sounding but did not see anyone. Staff I stated she went outside, looked around but still did not see anyone. When she came inside, she saw Resident #2 in the hallway and the resident told her he saw a tall man leaving out of the side door and he believed it was a family member. She then went to the secured unit but did not see any staff. Staff I stated she did not call out to anyone but walked down the hall about halfway and did not see any staff on the unit. Staff I stated there had always been problems with the door to the secured unit closing well and she had noticed the door did not always close and lock. She never reported it because she felt administrative staff were aware as facility nurses told her about the door when she stared working at the facility in February 2024. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on [DATE] at 4:15 p.m. Resident #2 stated his room was located on Hall 200 next to the side door where Resident #1 left the facility. He stated the therapy gym was also near the same door. He stated on the night of [DATE] at approximately 7:00 p.m. a tall Black man carrying a bag walked past his room and shortly after the door alarm sounded. He stated he thought the man was a visitor leaving through the wrong door by accident. Resident #2 stated a lady from therapy came out and asked if someone had gone through the door and he told her he thought it was a family member. He stated the alarm sounded for approximately , d+[DATE] minutes before the lady from therapy turned it off. He stated he had been on the secured unit before because that was where his Hall 200 nurse was located. He had observed the door to the unit not always closing and locking. In an interview on [DATE] at 11:58 a.m. the DON stated she had worked at the facility since February 2024, and sometimes if the crash bar on the secured unit door was not hit hard enough it would not close or lock. She stated the problem with the door had existed for at least two months. The DON stated she thought she had reported the problem with the door to the Administrator sometime in [DATE]. The DON further stated the door installer had come out to check the door and he said the door was, Ok. The installer felt staff were not hitting the crash bar hard enough. She stated she had no further concerns related to the door. Staff were aware to check the door to make sure it closed and locked. In an interview on [DATE] at 12:56 p.m. the facility's Medical Director stated he was not familiar with the staffing patterns on the secured unit. When informed that the nurses and CNAs assigned to the secured unit were also assigned residents who resided outside of the unit, he stated it would be best to have one CNA designated for the unit. When queried why this would be better, he stated it would be better so that staff would not have to leave the unit to provide care. Observation on [DATE] at 1:25 p.m. revealed Resident #1 was ambulating on the secured unit speaking unintelligently to staff. In an interview on [DATE] at 1:43 p.m. medical records staff stated he was on duty and working on Hall 100 during the evening of [DATE] when Resident #1 eloped. He stated just before he heard the alarm, he saw two dietary staff going out of the side door on Hall 100 and thought they had caused the alarm to sound. He stated the alarm only sounded for a couple of minutes and someone had to have manually silenced it. In an interview on [DATE] at 6:00 p.m. The DON stated it was important that there were staff on the secured unit at all times. She stated residents on the secured unit did not have the mental capacity to make safe judgements and if no staff were on the unit to supervise the residents the residents would be at risk for harm. The DON stated it was important for the door on the secured unit to close and lock properly to prevent residents from leaving because the locked door was a safety measure put into place to maintain safety of the residents. The DON stated if the secured unit door did not close and lock properly residents could exit, get lost and be harmed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's policy/procedure entitled Wandering Residents/Secure Unit Resident revised [DATE] revealed every effort would be made to prevent wandering episodes while maintaining the least restrictive environment for residents who were at risk for elopement. Interventions would be entered onto the resident's care plan and medical record. The resident would be placed on the secure unit after receiving a physician's order and obtaining consent. The policy/procedure reflected if an elopement incident occurred, contributing factors would be investigated and remedied to prevent a reoccurrence. Review of the facility's policy/procedure entitled Safety and Supervision of Residents revised [DATE] revealed employees would be trained on potential accident hazards, demonstrate competency on how to identify/report accident hazards, and try to prevent avoidable accidents. Resident supervision was listed as the core component of the systems approach to safety. The type and frequency of resident supervision would be determined by the individual resident's assessed needs and identified hazards in the environment. Risk and environmental hazards included unsafe wandering. Review of the facility's undated procedure entitled Door Alarms revealed staff were to go outside and walk around the facility to check for a resident if an alarm sounded. If no resident was located outside, the charge nurse was to be notified that an alarm was going off and the outside had been checked. The charge nurse should complete a total head count of residents. This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 5:25 p.m. The Administrator was informed of an IJ in the area of accidents/supervision and was provided with the IJ template via email on [DATE] at 5:28 p.m. The following Plan of Removal submitted by the facility was accepted on [DATE] at 1:25 p.m.: On [DATE] Elopement Risk Assessment completed for each resident in the facility, All residents identified to be at risk for elopement orders have been verified and secure unit placement confirmed. To remedy concerns regarding resident elopement at the facility implemented the following changes, 1. In-service for all staff initiated by the Administrator on [DATE] to educate staff on proper response to ensure resident safety when facility door alarm sounds. 2. Staff who have not signed in-service will be contacted and are not allowed to work until signatures and education is complete. 3. Administrator and Maintenance Supervisor met at facility on [DATE] after notification of missing resident. Each door was checked and worked as intended. 4. Facility implemented Policy and Procedure with specific staff instructions on guidance for Elopement Procedure if Alarm Sounds or it is identified we have a missing resident. 5. Administrator and RDO checked the following exit doors on [DATE] to ensure proper functioning of door alarm, mag lock, code alert or keypad, and push bar on Secure Unit Doors on 200, Hall Large Dining Room, and 200 Hall Secure Unit Entrance will be replaced. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	6. Secure Unit Doors for 200 Hall Large Dining Room and 200 Hall Secure Unit will be continuously monitored by staff until push bars are replaced. The facility is anticipating arrival of new push bars on [DATE] in the late afternoon. Plan is to have the new push bars installed [DATE]. 7. The DON completed a head count of all secure unit residents on [DATE] at 5:40 and all residents were accounted for. 8. A new order was added [DATE] for all residents on the Secure Unit which will require visual checks along with documentation that every resident is present and accounted for on Secure Unit. The facility Medical Director was notified on [DATE]st of facility action plan and to offer any suggestions. This plan was implemented [DATE]. This action plan will be monitored through personal observation by the Administrator and verbal reports to the Regional Director of Operations. Review of in-service training material and logs dated [DATE] and [DATE] revealed education included the facility's elopement policy/procedure, maintenance logs, door alarm response procedures, and that there should be staff on the secured unit at all times. Staff were provided training related to visual checks of residents on the secured unit and new orders for all residents on the secure to document residents were present and accounted for each shift. Interviews were conducted with facility staff from various shifts on [DATE] from 5:00 p.m. to 5:45 p.m. Staff interviewed were LVN B, LVN C, CNA J, CNA K, LVN L, CNA M, LVN N, dietary aide O, and the Dietary Manager. Interviews with the staff revealed they verbalized comprehension of the in-service training. They stated they had been in-serviced on responding to all alarms to ensure resident safety, how to check the panel on the halls to determine what door alarm was sounding, conducting a resident head count, full searches inside/outside of the facility, and ensuring they searched each side of the building outside. Nurses were aware that all residents on the secured unit had new physician orders to check and ensure the residents were accounted for each shift. Staff verbalized understanding that both the CNA and nurse could not be off the secured unit at the same time under any circumstance to ensure residents were being supervised at all times. The Administrator was informed the Immediate Jeopardy was removed on [DATE] at 6:20 p.m. The facility remained out of compliance at the severity level of potential for more than minimal harm that is not immediate jeopardy and at a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15315 Based on observations, interviews, and record review, the facility failed to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment for 11 of 11 residents (Resident #1, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, Resident #8, Resident #9, Resident #10, Resident #11, and Resident #12) residing on the secured unit. 1. The facility failed to assign designated staff for the secured unit, frequently leaving Resident #1, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, Resident #8, Resident #9, Resident #10, Resident #11, and Resident #12 who were all cognitively impaired and at risk for elopement, unattended for indeterminate amounts of time when assigned staff provided care to residents in other parts of the building. 2. The facility failed to ensure staff was available to supervise residents on the secured unit when Resident #1 eloped from the facility on 04/30/24. On 05/02/24 at 10:51 a.m. an Immediate Jeopardy was identified. While the Immediate Jeopardy was removed on 05/02/24, the facility remained out of compliance at a severity level of potential for more than minimal harm that is not immediate jeopardy and at a scope of pattern due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. These failures placed residents at risk of inadequate supervision, an unsafe environment, falls, serious harm, injury, abuse, and death. Findings included: 1. Review of Resident #1's active physician orders dated 05/2024 revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included cocaine abuse, intracerebral hemorrhage (type of stroke, interruption of blood flow to a part of the brain either by a blockage or rupture of a blood vessel), and encephalopathy (encephalopathy-a group of conditions that cause brain dysfunction. Brain dysfunction can appear as confusion, memory loss, personality changes and/or coma in the most severe form). Review of Resident #1's quarterly MDS assessment, dated 03/12/24, revealed the resident's BIMS score was 3 indicating severe cognitive impairment. Review of Resident #1's care plan dated reviewed 04/30/24 revealed the resident's risk for elopement due to poor safety awareness was addressed. Goals included the resident would not leave the facility or the property unattended. The only intervention was to house the resident on the secured unit for safety. The care plan addressed the resident's elopement on 04/29/24 but did not include any additional interventions. (continued on next page)

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	675810	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lancaster Ltc Partners Inc	1515 N Elm St Lancaster, TX 75134

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's current Elopement Risk Assessments dated 10/26/24 and 04/30/24 reflected the resident had been assessed to be at risk for elopement. Observation on 05/02/24 at 1:25 p.m. revealed Resident #1 was ambulating on the secured unit speaking unintelligently to staff. 2. Review of Resident #3's undated Admission Record revealed the resident was an [AGE] year-old male with admitted s of 05/01/23 and 04/15/24. His diagnoses included Alzheimer's disease. Resident #3's current MDS assessment dated [DATE] reflected a BIMS score of 8 indicating moderately impaired cognition. Review of Resident #3's care plan revised 04/30/24 revealed the resident's risk for elopement was addressed. Goals included the resident not leaving the facility or the property unattended. The only intervention was to house the resident on the secured unit. Review of Resident #3's current Elopement Risk Assessments dated 04/30/24 revealed the resident had been assessed to be at risk for elopement. 3. Review of Resident #4's undated Admission Record revealed the resident was a [AGE] year-old male with an admitted [DATE]. His diagnoses included dementia (a progressive or persistent loss of intellectual functioning). Resident #4's current MDS assessment dated [DATE] reflected a BIMS score of 2 indicating severe cognitive impairment. Review of Resident #4's care plan revised 04/30/24 revealed the resident's risk for elopement due to poor safety awareness was addressed. Goals included the resident not leaving the facility or the property unattended. The only intervention was to house the resident on the secured unit. Review of Resident #4's current Elopement Risk Assessments dated 04/30/24 revealed the resident had been assessed to be at risk for elopement. Observation on 05/02/24 at 2:06 p.m. Resident #4 was ambulating on the secured unit, assisted to the bathroom by CNA M, and much encouragement was required. The CNA stated the resident was incontinent at times. 4. Review of Resident #5's undated Admission Record revealed the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included traumatic brain injury (happens when a sudden, external, physical assault damages the brain). Resident #5's current MDS assessment dated [DATE] reflected cognitive skills for daily decision making were severely impaired. Review of Resident 5's care plan revised 05/02/24 revealed the resident's risk for elopement due to poor safety awareness was addressed. Goals included maintaining the resident's safety and interventions included housing the resident on the secured unit. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #5's current Elopement Risk Assessments dated 04/30/24 revealed the resident had been assessed to be at risk for elopement. Observation on 05/02/24 at 2:22 p.m. Resident #5 was resting in bed and noted to be incontinent of urine. 5. Review of Resident #6's undated Admission Record revealed the resident was a [AGE] year-old female with admitted s of 02/13/24 and 02/21/24. Her diagnoses included Alzheimer's disease. Resident #6's current MDS assessment dated [DATE] reflected a BIMS score of 2 indicating severe cognitive impairment. Review of Resident 6's care plan revised 04/30/24 revealed the resident's risk for elopement due to poor safety awareness was addressed. Goals included the resident not leaving the facility or the property unattended. The only intervention was to house the resident on the secured unit. Review of Resident #6's current Elopement Risk Assessments dated 04/30/24 revealed the resident had been assessed to be at risk for elopement. Observation on 05/02/24 at 2:10 p.m. Resident #6 was ambulating on the secured unit. The resident had experienced an incontinent episode and was combative and resistant to care. 6. Review of Resident #7's undated Admission Record revealed the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included dementia. Resident #7's MDS assessment dated [DATE] reflected the resident's cognitive skills for daily decision making were modified independence. Review of Resident 7's care plan revised 04/30/24 revealed the resident's risk for elopement was addressed. Goals included the resident not leaving the facility or property unattended. The only intervention was to house the resident on the secured unit. Review of Resident #7's current Elopement Risk Assessments dated 04/30/24 revealed the resident had been assessed to be at risk for elopement. 7. Review of Resident #8's undated Admission Assessment revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included dementia. Resident #8's current MDS assessment, dated 03/08/24, reflected the resident's BIMS score was 1 indicating severe cognitive impairment. Review of Resident 8's care plan revised 04/30/24 revealed the resident's risk for elopement due to poor safety awareness was addressed. Goals included the resident not leaving the facility or the property unattended. Interventions included the resident was housed on the secured unit for safety. An intervention dated 05/02/24 was that the resident would be present and accounted for on the secured unit. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #8's current Elopement Risk Assessments dated 04/30/24 revealed the resident had been assessed to be at risk for elopement. 8. Review of Resident #9's undated Admission Record revealed the resident was an [AGE] year-old male with an admitted [DATE]. His diagnoses included dementia. Resident #9's current MDS assessment dated [DATE] reflected the resident's cognitive skills for daily decision making were moderately impaired. Review of Resident #9's care plan revised 03/12/24 revealed the resident's risk for elopement was addressed. The goal was that the resident would not leave the facility or property unattended. The only intervention was to house the resident on the secured unit. Review of Resident #9's current Elopement Risk Assessments dated 04/30/24 revealed the resident had been assessed to be at risk for elopement. 9. Review of Resident #10's undated Admission Record revealed the resident was a [AGE] year-old male with admitted s of 11/10/23 and 02/07/24. His diagnoses included encephalopathy. Resident #10's current MDS assessment dated [DATE] reflected a BIMS score of 9 indicating moderately impaired cognition. Review of Resident #10's care plan revised 04/30/24 revealed the resident's risk for elopement was addressed. The goal was that the resident would not leave the facility or property unattended. The only intervention was to house the resident on the secured unit. Review of Resident #10's current Elopement Risk assessment dated [DATE] revealed the resident had been assessed to be at risk for elopement. 10. Review of Resident #11's undated Admission Record revealed the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included Alzheimer's disease and dementia. Resident #11's current MDS assessment, dated 04/12/24, reflected the resident's BIMS score was 2 indicating severe cognitive impairment. Review of Resident #11's care plan revised 05/19/23 revealed the resident's risk for elopement due to poor safety awareness was addressed. Goals included the resident not leaving the facility or the property unattended. The only intervention was to house the resident on the secured unit for safety. Review of Resident #11's current Elopement Risk Assessments dated 04/30/24 revealed the resident had been assessed to be at risk for elopement. 11. Review of Resident #12's undated Admission Record revealed the resident was a [AGE] year-old female with admitted s of 11/29/23 and 06/24/23. Her diagnoses included dementia. Resident #12's current MDS assessment dated [DATE] reflected a BIMS score of 2 indicating severe cognitive impairment. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #12's care plan revised 04/30/24 revealed the resident's risk for elopement was addressed. Goals included the resident not leaving the facility or the property unattended. The only intervention was to house the resident on the secured unit. Review of Resident #12's current Elopement Risk Assessments dated 04/30/24 revealed the resident had been assessed to be at risk for elopement. Observation on 04/30/24 at 11:20 a.m. of the secured unit entrance door located on Hall 200 revealed no code was required for entry. Entrance only required pressing the crash bar on the door. A code was required to exit and there was no alarm on the door. There was one nurse and one CNA working on the unit. In an interview on 04/30/24 at 11:20 a.m. LVN B stated there was one nurse assigned to the secured unit and one CNA. She stated she was also assigned to Hall 200 directly outside the unit and the CNA was assigned to additional residents on Hall 100 outside the unit. LVN B further stated when she left the unit to provide care on Hall 200 the CNA stayed on the unit to monitor the residents. In an interview on 04/30/24 at 2:45 p.m. the Administrator stated Resident #1 exited the secured unit and eloped from the facility on the evening of 04/29/24. She stated she was notified at approximately 10:00 p.m. on 04/29/24 that the resident was missing. The police were notified, and staff searched inside, outside the facility, and the surrounding neighborhood. The search continued through the morning of 04/30/24 and the resident was located at approximately 11:00 a.m. on 04/30/24, 2.6 miles from the facility. Resident #1 was assessed and evaluated at the hospital without injury. In an interview on 04/30/24 at 3:30 p.m. LVN A stated he was the charge nurse on duty during the evening shift on 04/29/24 when Resident #1 eloped from the facility. He stated he last saw the resident at approximately 6:30 p.m. sitting in the secured unit dining room. LVN A stated he went to pass medications to residents residing outside the secured unit on Hall 200 at approximately 6:00 p.m. After he completed his medication pass, he went outside for a 15-minute break and returned to the unit. He stated at the time he took his break he could not say who remained on the secured unit to supervise the residents. LVN A stated he noticed Resident #1 was missing sometime around 8:00 p.m. or 9:00 p.m. The staff searched the inside and outside of the facility. After staff were unable to locate Resident #1, he called the code for missing resident (code purple) and notified the DON. All staff began searching all areas in the facility. LVN A stated while he was providing care on Hall 200 outside the secured unit it was possible that someone could have entered and/or exited the unit and not ensured the door fully closed and locked. LVN A stated there should always be someone on the secured unit at all times, but he had to take care of residents on Hall 200. He stated staffing on the secured unit was always one nurse and one CNA as it was on 04/29/24 . In an interview on 05/01/24 at 12:32 p.m. CNA F stated CNAs assigned to the secured unit were also assigned to provide care to residents residing outside the unit on Hall 100. She stated staff have been asking for an extra person so that the CNA assigned to the unit could remain on the secured unit. She stated, usually the nurse, or the CNA would stay on the unit while the other provided care for their assigned residents residing outside the unit. She stated it was not always possible for there to be at least one staff on the unit at all times. She stated the CNA that worked the secured unit also took care of residents on the bottom section of Hall 100. CNA F further stated after Resident #1's elopement on 04/29/24 the assignment had changed to one CNA assigned and designated to work only on the secured unit. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 05/01/24 at 3:19 p.m. CNA H stated she had worked at the facility for three days and the only time she had worked on the secured unit was during the day shift (6:00 a.m. to 6:00 p.m.) on 04/29/24. She stated she left the faciity on [DATE] at approximately 6:02 p.m. and Resident #1 was sitting in the day area. She further stated no one was on the unit with the residents when she left but as she was leaving the charge nurse (LVN A) was coming inside the facility through the front door. CNA H when queried about leaving the residents on the unit unsupervised, CNA H stated she did not feel comfortable, but she had to leave. She stated if she had not seen the nurse returning inside the facility, she would have gone back to the unit. CNA H stated she did not know if the nurse went directly back to the unit when she saw him entering the facility. In an interview on 05/01/24 at 3:35 p.m. the Administrator stated facility staffing patterns for all shifts on the secured unit were one nurse who was also the charge nurse for Hall 200. There was one CNA who worked the secured unit and the bottom half of Hall 100. She stated the staffing pattern for the secured unit had changed since Resident #1's elopement on 04/29/24. The new staffing pattern implemented for the secured unit was that one CNA assigned would be solely designated to the unit. The Administrator further stated during a staff meeting today (05/01/24) she had reiterated the importance of there being at least one staff on the secured unit at all times for resident safety . Training records dated 09/28/22 reflected topics included the secured unit, but no information related to what was included in the training. In an interview on 05/02/24 at 11:58 a.m. the DON stated her expectation was that there should be a staff member on the secured unit at all times. The staff on the secured unit should work as a team and cover for each other when one has to leave the unit. The DON further stated staff should make alternate rounds to ensure one staff was present on the unit at all times. Her expectations included nurses making walking rounds when they arrive to work and before they leave. The DON stated there was no documented evidence, but she had verbally informed all staff of her expectations. In an interview on 05/02/24 at 12:56 p.m. the facility's Medical Director stated he was not familiar with the staffing patterns on the secured unit. When informed that the nurses and CNAs assigned to the secured unit were also assigned residents who resided outside of the unit, he stated it would be best to have one CNA designated for the unit. When queried why this would be better, he stated it would be better so that staff would not have to leave the unit to provide care . In an interview on 05/02/24 at 6:00 p.m. the DON stated it was important that there was staff on the secured unit at all times. She stated residents on the secured unit did not have the mental capacity to make safe judgements and if no staff were on the unit to supervise the residents the residents would be at risk for harm. Review of the facility's Assessment Tool dated 06/19/23 revealed staffing on the secured unit was not listed. Review of the facility's policy/procedure entitled Staffing dated revised 10/2017, revealed the facility's policy statement reflected the facility would provide sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	This was determined to be an Immediate Jeopardy (IJ) on 05/02/24 at 10:51 a.m. The Administrator was informed of an IJ in the area of sufficient staffing and the IJ template via email at 11:12 a.m. The following Plan of Removal submitted by the facility was accepted on 05/02/24 at 4:31 p.m. and reflected: On 5/2/24, the Administrator initiated in-service for all Nursing Staff that there must be a Nursing Employee (RN, LVN, or Aide) on the Secure Unit at all times. On 5/2/24 the DON changed aide assignments to ensure there is 1 Aide Staffed in the Unit at all times. On 5/2/24 the DON initiated in-service with all aides regarding new assignment that an aide must remain on Secure Unit at all times. To remedy concerns regarding Secure Unit Staffing at [facility name] the facility implemented the following changes, 1. Nursing staff who have not signed in-services will be contacted and are not allowed to work until completed 2. Administrator to monitor schedule on a daily basis during facility IDT (Interdisciplinary Team) Meeting to ensure aide is assigned at all times on Secure Unit. The facility Medical Director [physician name] was notified on May 2nd of facility action plan and to offer any suggestions. This plan was implemented May 2,2024. This action plan will be monitored through personal observation by the Administrator and verbal reports to the RDO. Review of in-service training material and logs dated 04/29/24 and 05/01/24 revealed education included the facility's elopement policy/procedure, dedicated staff assigned to the unit, coordination between the nurse and CNA to ensure there would be staff on the secured unit at all times to supervise residents. Interviews were conducted with facility staff on 05/02/24 from 5:00 p.m. to 5:45 p.m. Staff interviewed were LVN B, LVN C, CNA J, CNA K, LVN L, CNA M, LVN N, dietary aide O, and the Dietary Manager . Interviews with the staff revealed they verbalized comprehension of the in-service training. They stated they had been in-serviced on new physician orders to check and ensure and document residents on the secured unit were accounted for each shift. Staff verbalized understanding that both the CNA and nurse could not be off the secured unit at the same time under any circumstance to ensure residents were being supervised at all times. The Administrator was notified on 05/02/24 at 6:20 p.m. that the Immediate Jeopardy was removed. However, the facility remained out of compliance at the severity level of potential for more than minimal harm that is not immediate jeopardy and at a scope of pattern due to the facility continuing to monitor the implementation and effectiveness of their plan of removal.