STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675820	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lennwood Nursing and Rehabilitation	8017 W Virginia Dr Dallas, TX 75237

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45053 Based on interviews, and record reviews, the facility failed to ensure that all alleged violations involving abuse, neglect are reported immediately, but not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the State Survey Agency in accordance with State law through established procedures for 1 of 6 residents (Resident #1) reviewed for abuse and neglect, in that: The facility did not report an incident of potential neglect for Resident #1 to the State Survey Agency within 24 hours, when Resident #1 eloped from the facility on 03/28/25 through the facility's exit door, that did not alarm when opened. This deficient practice could place residents at-risk of not having incident and accident investigations reported within the timeframe required. reported appropriately. Findings included: Record review of Resident #1's Face Sheet, dated 05/06/25, revealed the resident was an [AGE] year-old male admitted to the facility on [DATE]. The resident's diagnoses included: dementia, gout (a form of inflammatory arthritis caused by the buildup of uric acid crystals in the body, leading to sudden, severe pain, swelling, and redness in one or more joints), acute kidney failure, Type 2 diabetes, oropharyngeal dysphagia (difficulty swallowing that specifically occurs in the oral cavity and throat), lack of coordination, and major depressive disorder. Record review of Resident #1's Quarterly MDS assessment, dated 03/11/25, revealed the resident had a BIMS score of 3 indicating severe cognitive impairment. In Section P0200. Alarms indicated Resident #1 had a Wander/elopement alarm. Record review of Resident #1' Care Plan, dated 02/21/25, revealed: Focus: [Resident #1] use psychotropic medications r/t Dementia. Date Initiated: 06/20/2024 (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Revision on: 04/18/2025 Cancelled Date: 04/16/2025 Goal: [Resident #1] will be/remain free of drug related complications. Date Initiated: 06/20/2024 Revision on: 04/16/2025 Target Date: 04/07/2025 Cancelled Date: 04/16/2025 Interventions/Tasks: Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 06/20/2024 Revision on: 04/16/2025 Cancelled Date: 04/16/2025 Consult with pharmacy, MD to consider dosage reduction when clinically appropriate. Date Initiated: 06/20/2024 Revision on: 04/16/2025 Cancelled Date: 04/16/2025 Discuss with MD, family re ongoing need for use of medication. Date Initiated: 06/20/2024 Revision on: 04/16/2025 Cancelled Date: 04/16/2025 Monitor/record occurrence for target behavior symptoms like pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others. etc. and document per facility protocol. Date Initiated: 06/20/2024 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Revision on: 04/16/2025 Cancelled Date: 04/16/2025 [Resident #1] is an elopement risk/wanderer. Date Initiated: 03/27/2025 Revision on: 04/16/2025 Cancelled Date: 04/16/2025 [Resident #1's] safety will be maintained through the review date. Date Initiated: 03/28/2025 Revision on: 04/16/2025 Target Date: 04/07/2025 Cancelled Date: 04/16/2025 Assess for fall risk. Date Initiated: 03/27/2025 Revision on: 04/16/2025 Cancelled Date: 04/16/2025 Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book . Date Initiated: 03/27/2025 Revision on: 04/16/2025 Cancelled Date: 04/16/2025 Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate [sic]. Date Initiated: 03/27/2025 Revision on: 04/16/2025 Cancelled Date: 04/16/2025 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes. Date Initiated: 03/27/2025 Revision on: 04/16/2025 Cancelled Date: 04/16/2025 WANDER ALERT: Device # Model Date Initiated: 03/27/2025 Revision on: 04/16/2025 Cancelled Date: 04/16/2025 Record review of Resident #1's Social History and Initial Assessment revealed on Page 2, Question 9. Current Behavioral Status was checked as No behavioral Concerns. The document was signed and dated by the previous Social Worker on 06/24/24. Resident #1's family member provided the information to the previous Social Worker for the Social History and Initial Assessment. Record review of the Order Summary for Resident #1 revealed a Physician Telephone Order on 01/21/2025 for WANDERGUARDS: LEFT ANKLE.CHECK FOR PLACEMENT AND PROPER WORKING FUNCTION every shift. Record review of Resident #1's MAR for January 2025 - March 2025 revealed that Resident #1's Wanderguard Checklist was marked with a check markevery day during the Day, Evening and Night Shifts and was in operable condition. The MAR did not reveal any timestamps for Resident #1's Wanderguard Checklist for the Day, Evening, and Night Shifts on 03/27/25. The MAR did not reveal any timestamps for Resident #1's Wanderguard Checklist for the Day and Evening Shifts on 03/28/25. Record review of Resident #1's Elopement Evaluation on 03/28/25 revealed, an Assessment Outcome Score of 9 indicating Resident #1 was at Risk of Elopement. Record review of Resident #1 Assessments revealed that there was not an Elopement Evaluation for him prior to 03/28/25. Record review of Nurse Progress Notes from LVN A on 03/28/25 at 3:33 AM, revealed: resident was seen sitting in w/c in day area on when coming from helping another resident, he was gone down the hallway walking and pushing his w/c down by the breakroom area. then vanishes when no one seen him or heard any alarms. [Staff] begins to look for him along with nurses notified police, don, and family. resident was located across from facility ground in apartment complex. resident was brought back and evaluated with minor scratch on his chin and his left hand ring finger resident has no complaints. resident is in b/r laying down in bed resting with eyes closed with staff member doing 15 minutes check while asleep WCTM. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Nurse Progress Notes from LVN A on 03/28/25 at 3:48 PM, revealed: Elopement Evaluation: History of elopement while at home: Yes. Wandering behavior a pattern or goal-directed: Yes. Wanders aimlessly or non-goal-directed: Yes. Wandering behavior likely to affect the safety or well-being of self / others: Yes. Wandering behavior likely to affect the privacy of others: Yes. Recently admitted or readmitted (within past 30 days) and has not accepted the situation: Yes. Elopement Score: 9.0. Record review of Nurse Progress Notes from the SW's Late Entry on 03/31/25 at 12:30 PM, Effective: 03/28/25 at 12:26 PM revealed, This writer called representative to inform her of resident needing to be placed at another facility due to elopement risk. Resident representative stated she got a call from other facility regarding accepting him and I informed yes referral sent out to see if there would be anyone who would accept him. Record review of Nurse Progress Notes from CNA B's Late Entry on 03/28/25 at 13:42 [1:42 PM], Effective 03/28/25 at 12:44 PM revealed, The resident transferred to [another facility's] Secure Nursing Unit via wheelchair transport with medications and personal belongings at this time. The resident was cooperative prior to exiting the facility. No noted signs and symptoms of respiratory distress and denies discomfort prior to exiting the facility. Report called to [staff] at [another facility's] memory Care Unit. Record review of the facility's Provider Investigation Reports Fax Cover Sheet dated 04/03/25 revealed the following: Intake ID No: NO SR # received - Called in by [DON] on hotline. Record review of the facility's Provider Investigation Report revealed the following: Incident Date: 03/28/25. Time of Incident 3:20 AM. Staff reported [Resident #1], eloped from the facility to the apartment complex across the road. Record review of the facility's Provider Investigation Report's Investigation Summary section of the report reflected: [Resident #1] was brought back to the facility by the DON. Resident received treatment for his scrapes to his chin and finger. Resident placed on Q:15 minute checks. Family notified of need for secure unit and family in agreement. Facility transferred [Resident #1] to [another facility] on 03/28/2025 with resident belongings. The police department were notified about the incident. Record review of the facility's Provider Investigation Report's Facility Investigation Findings section of the report reflected: Confirmed. Record review of the facility's Provider Investigation Report's, Provider Action Taken Post-Investigation section reflected: Elopement In-Service, Wanderguard system checked with no issues identified. Record review of the facility's Provider Investigation Report's view of TULIP on 05/07/25 at 12:00 PM reflected, the incident report for elopement of Resident #1 on 03/28/25 was not uploaded. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 05/05/25 at 2:25 PM, with Resident #1's family member, she stated that Resident #1 was a resident at the facility for almost 1 year. She stated that prior to Resident #1 being admitted to the facility, he was living with the family member and he had about 2-3 elopement incidents, in which a decision was made to have Resident #1 reside at a Nursing Facility. She stated that initially Resident #1 was admitted to the facility after a hospital stay, which led to him needing physical therapy. She stated that during Resident #1's stay at the facility, she realized that Resident #1 had to be at the facility long term due to his dementia and exit seeking. The family member stated that she did not initially inform the facility that Resident #1 had exit seeking behaviors and had previously eloped from home prior to being admitted to the facility. She stated that no one asked her if Resident #1 was exit seeking or had some elopement incidents while he was staying at her home. She stated that no one asked her about Resident #1's previous elopement history, therefore she did not tell them. The family member stated that Resident #1 had a Wanderguard brace on his ankle due to him exit seeking at the facility. The family member stated that on 03/28/25 at approximately 3 AM, another family member notified her via telephone informing her that their family member had exited the facility although he was wearing a Wanderguard on his ankle and was found at the apartment complex across the street attempting to climb a fence. The family member stated that the neighbor at the apartment complex across observed Resident #1 and asked him, what are you doing? Resident #1 replied, I am trying to go to work, and you can call my [family member], he will come and get me. Resident #1 provided the telephone number for his family member. The neighbor at the apartment complex across the street from the the facility, then called 911 and told them about the incident and then telephoned Resident #1's family member. According to the family member, Resident #1's other family member called the facility and notified the staff at the facility that Resident #1 was not in the facility and the staff were unaware that Resident #1 had eloped from the facility. The family member stated that the police arrived at the apartment complex across the street from the facility and returned the resident to the facility. Resident #1 was then transferred to another facility on 03/28/25, the same day of his elopement. According to the family member, Resident #1 did not receive any serious injuries from eloping from the facility. On 05/06/25 at 12:00 PM an attempt to interview the previous DON via telephone was unsuccessful. On 05/06/25 at 12:15 PM an attempt to interview LVN A via telephone was unsuccessful. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the SW on 05/06/25 at 4:31, she stated that she was not at work when Resident #1 eloped from the facility on 03/28/25 due to the incident occurring around 3 AM. The SW stated that she received a telephone call during the night by the previous DON stating that during the night shift of 3/27/25 and early morning of 03/28/25. She stated that she was asleep during the original voicemail from staff and in the morning, she woke up and listened to her voicemail message. She stated that she later learned that staff noticed that Resident #1 was missing, and they looked inside the building, and he was not in the building. The SW stated that staff went to look for Resident #1 outside the facility and he was found across the street at an apartment complex. The SW stated that Resident #1 had a Wanderguard on his leg and was exit seeking according to staff but had never exited the facility prior to the incident when he eloped on 03/28/25. The SW stated that according to the staff's records for Resident #1 had a Wanderguard Test on on 03/27/25 and 03/28/25 and it was working properly. She stated that staff sent an alert made for Resident #1 due to his eloping from the facility and then the staff began looking for him She stated that the facility was not aware that the resident had any elopement issues. She stated that if the facility was informed during Pre-Admission that any resident had any previous elopement issues, the facility would have not admitted that person to the facility. She stated that there are not any Power of Attorneys on file for Resident #1 and he was his own RP. The SW stated that she and staff were In-Serviced on Abuse, Neglect and Elopement Procedures and Guidelines after the incident involving Resident #1 eloping from the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Administrator on 05/06/25 at 4:53 PM, she stated that she was on vacation when Resident #1 eloped from the facility during the evening shift on 03/28/25. She stated that prior to her leaving for vacation, she provided directions to the previous DON on how to report allegations to HHSC via telephone. She stated that she is the Abuse Coordinator for the facility and when she returned to work at the facility, the previous DON updated her on the situation involving Resident #1's elopement on 03/28/25. The Administrator stated that the previous DON told her that Resident #1 exited the facility using the front door and was found across the street at an apartment complex. She stated that a man that lived in the apartment complex across the street witnessed him and law enforcement was notified. The previous DON went across the street to get Resident #1 and brought him back to the facility. She stated that Resident #1 did not have any serious injuries according to his head-to-toe Assessment that was given by LVN A. She stated that Resident #1 was placed on 1:1 observation after the incident and a staff member was always with him. She stated that the previous DON stayed with Resident #1 until the next shift began at 6 AM. The Administrator stated that Resident #1's Emergency Contacts, Doctor and Behavioral Health were notified of Resident #1's elopement. She reported that Resident #1 had been at the facility for approximately 1 year and there was not any previous history of Resident #1 having any elopement issues or concerns prior to him being admitted to the facility. She stated that if the facility learned that Resident #1 was exit seeking or had any prior elopement concerns, he would not have been admitted to the facility because the facility is not equipped to have a Secured Unit. She stated that the SW then began to find placement for Resident #1 at a facility that had a Secure Unit. She stated that Resident #1 was discharged to another facility with a Secured Unit on 03/28/25. She stated that when the previous DON told her that she called in a report to HHSC after Resident #1's elopement, she told her that she did not receive an Intake or Report number. The Administrator stated that she did not confirm or follow-up with HHSC regarding the situation because she thought that the previous DON had already made a Self-Report. She stated that she always uses TULIP to make Self-Reports to HHSC and had never used the telephone number for HHSC to call in a Self-Report, therefore she did not know the procedure of calling in a Self-Report via telephone. She stated that since learning that there was not a Self-Report to HHSC for Resident #1's elopement, she will now review all Self-Reports that are called in to HHSC by the ADON and DON to ensure that a Self-Report was generated for all future incidents. She stated that Resident #1 had a Wanderguard per his doctor's order and his Wanderguard was tested 3 times a day, per his doctor's orders. She stated that no one knows how Resident #1 was able to exit the facility on 03/28/25 due to his Wanderguard and the exterior doors working in proper order. She stated that the staff were In-Serviced on abuse, neglect, and elopement procedures after Resident #1's elopement form the facility. In an interview with the Maintenance Supervisor on 05/06/25 at 5:45 PM, he stated that he had been employed at the facility since 04/12/25. He stated that he was not aware of the elopement incident on 03/28/25 by Resident #1. He stated that there was not any documentation showing that there were any issues with any of the exterior doors at the facility on 03/27/25 and 03/28/25. He stated that he does daily checks on all the doors in the facility. He stated that the exterior doors to the building have a fire alarm and will alert if they are opened. He stated that the front door of the facility will alert and made a ringing sound if a resident with a Wanderguard attempts to exit the front door. He stated that he and other facility staff regularly receive In-Service Trainings on Abuse, Neglect and Elopement Procedures and Protocols. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/07/25 at 1:15 PM ADON stated that prior to 03/28/25, she did not submit the facility's incident and reports, upload the information in TULIP or contact HHSC. She stated that the Administrator was responsible for doing the facility's incident and accident reports in TULIP. She stated that she was on leave when the incident occurred with Resident #1 eloping from the facility on 03/28/25 during the night shift. She stated that the Administrator was on leave also, and the previous DON notified her about the incident when she returned. She stated that the previous DON told her that she contacted HHSC and made report regarding Resident #1's elopement from the facility on 03/28/25. She stated that she was unaware that the previous DON did not report the elopement incident involving Resident #1. She stated that she, took the word of the previous DON and did not have any reason to believe that the previous DON did not call in the incident to HHSC. The ADON stated that the Administrator was on leave recently and gave her instructions on how-to call-in Incident Reports to HHSC via telephone. She stated that she called HHSC several times during the Administrators previous vacation, which included some Self-Reports that were being worked on for the current visit to the facility. The ADON stated that when she called HHSC to report Self-Reports, she received an Intake Number every time. She stated that she did not know how Resident #1 exited the building without his Wanderguard not alarming. She stated that Resident #1's Wanderguard was tested every day, 3 x's per day, per his doctor's orders. She reported that Resident #1's Wanderguard was tested on [DATE] on the Day, Evening and Night Shifts and it was working properly. The ADON stated that there were currently 5 residents at the facility with Wanderguards and each resident that has a Wanderguard has their Wanderguards tested per their doctors' orders and the results of each resident's Wanderguard is recorded on their MAR. She reported that Maintenance also tested the front door and there were not any issues with the front door or the other doors throughout the facility. She stated that no one knew how Resident #1 was able to exit the front door and elope from the facility. The ADON confirmed that all staff were given In-Service Trainings on Abuse, Neglect, Elopement and Supervision after the elopement incident involving Resident #1. On 05/07/25 at 10:33 AM an attempt to interview the previous DON via telephone was unsuccessful. In an interview with CNA C on 05/07/25 at 10:44 AM, she stated that she had been employed at the facility for 1 year. She stated that she was not at the facility on 03/28/25 due to being off duty. She stated that Resident #1 had dementia and during her shifts was observed coming close to the side door on his hallway. She stated that he had not observed Resident #1 exit any doors from the facility. She stated that when she returned to work, she was informed by staff that Resident #1 had exited the building during the night shift on 03/27/25 - 03/28/25. She stated that the night shift duty hours are 10 PM - 6 AM. She stated that Resident #1 did not receive any serious injuries according to his skin assessment on 03/28/25. She stated that all staff receive trainings throughout each week on abuse, neglect, and elopement. She stated that she remembered that she received an In-Service Training on Elopement after the incident on03/28/25 when Resident #1 eloped from the facility. On 05/07/25 at 11:16 AM an attempt to interview LVN A via telephone was unsuccessful. On 05/07/25 at 11:18 AM an attempt to interview CNA D via telephone was unsuccessful. Record review of the facility's In-Service Trainings revealed that all staff were in-serviced on the facility's abuse, neglect and elopement policies and procedures, elopement, risk assessments, skin assessments, notification to PCP and RP on 04/01/25. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's In-Service Trainings revealed all staff were in-serviced on the facility's abuse and neglect and policies and procedures on 04/23/25. The In-Service Training paperwork states, All staff if you see or suspect any forms of abuse/neglect towards a resident immediately remove the resident/report to the abuse coordinator [Administrator]. Record review of the facility's Abuse, Neglect and Exploitation Policy policy dated, 12/2024 revealed: Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property . Policy Explanation and Compliance Guidelines: 1. The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect . c. Include training for new and existing staff on activities that constitute abuse, neglect .reporting procedures, and dementia management and resident abuse prevention . 2. The facility will designate an Abuse Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law. 3. The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written. The components of the facility abuse prohibition plan are discussed herein: .VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. The Administrator should will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies. Record review of the facility's Guidelines for Resident Rights Guidelines for All Nursing Procedures dated, December 2024 revealed: Purpose: To provide general guidelines for resident rights while caring for the resident. Preparation: 1. Prior to having direct-care responsibilities for residents, staff must have appropriate in-service training on resident rights, including: a. Preventing, recognizing and reporting resident abuse; b. Resident dignity and respect . Record review of the facility's Resident Rights policy dated, December 2024 revealed: Policy Statement: Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; . b. be free from abuse, neglect .Record review of the facility's Resident Rights policy dated, December 2024 revealed: Policy Statement: Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; . b. be free from abuse, neglect . Record review of the facility's Elopements policy dated, December 2024 revealed: Policy Statement: Staff shall investigate and report all cases of missing residents. Policy Interpretation and Implementation: . (continued on next page)

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	675820	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lennwood Nursing and Rehabilitation	8017 W Virginia Dr Dallas, TX 75237

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. When a departing individual returns to the facility, the Director of Nursing Services or Charge Nurse shall: c. Notify the resident's legal representative (sponsor) of the incident; d. Complete and file Report of Incident/Accident; and e. Document the event in the resident's medical record. 4. If an employee discovers that a resident is missing from the facility, he/she shall: b. If the resident was not authorized to leave, initiate a search of the building(s) and premises, c. If the resident is not located, notify the Administrator and Direcgtor of Nursing Services, the resident's legal representative . 5. When the resident returns to the facility, the Director of Nursing Services or Charge Nurse shall: c. Notify the resident's legal representative; . e. Complete and file an incident report and self-report to your regulatory agency; and f. Document relevant information in the resident's medical record.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45053 Based on observations, record review, and interviews, the facility failed to ensure the resident environment remained as free of accident hazards as is possible and each resident received adequate supervision to prevent accidents for 1 (Resident #1) of 6 residents reviewed for quality of care. 1. The facility failed to ensure Resident #1, who had a history if eloping and wore a wandergaurd, was provided with adequate supervision to prevent him from eloping from the facility on 03/28/25. The facility concluded Resident #1 eloped through the facility's exit door that did not alarm when opened. 2. The facility failed to complete an elopement assessment for Resident #1 prior to his elopement on 03/28/25 The non-compliance was identified as past non-compliance. The Immediate Jeopardy (IJ) began 03/28/25 and ended on 04/01/25. The facility had corrected the non-compliance before the survey began. These failures placed residents at risk of harm and/or serious injury. Findings included: Record review of Resident #1's Face Sheet, dated 05/06/25, revealed the resident was an [AGE] year-old male admitted to the facility on [DATE]. The resident's diagnoses included: dementia, gout (a form of inflammatory arthritis caused by the buildup of uric acid crystals in the body, leading to sudden, severe pain, swelling, and redness in one or more joints), acute kidney failure, Type 2 diabetes, oropharyngeal dysphagia (difficulty swallowing that specifically occurs in the oral cavity and throat), lack of coordination, and major depressive disorder. Record review of Resident #1's Quarterly MDS assessment, dated 03/11/25, revealed the resident had a BIMS score of 3 indicating severe cognitive impairment. In Section P0200. Alarms indicated Resident #1 had a Wander/elopement alarm. Record review of Resident #1' Care Plan, dated 02/21/25, revealed: Focus: [Resident #1] use psychotropic medications r/t Dementia. Date Initiated: 06/20/2024 Revision on: 04/18/2025 Cancelled Date: 04/16/2025 Goal: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[Resident #1] will be/remain free of drug related complications. Date Initiated: 06/20/2024 Revision on: 04/16/2025 Target Date: 04/07/2025 Cancelled Date: 04/16/2025 Interventions/Tasks: Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 06/20/2024 Revision on: 04/16/2025 Cancelled Date: 04/16/2025 Consult with pharmacy, MD to consider dosage reduction when clinically appropriate. Date Initiated: 06/20/2024 Revision on: 04/16/2025 Cancelled Date: 04/16/2025 Discuss with MD, family re ongoing need for use of medication. Date Initiated: 06/20/2024 Revision on: 04/16/2025 Cancelled Date: 04/16/2025 Monitor/record occurrence for target behavior symptoms like pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others. etc. and document per facility protocol. Date Initiated: 06/20/2024 Revision on: 04/16/2025 Cancelled Date: 04/16/2025 [Resident #1] is an elopement risk/wanderer. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Date Initiated: 03/27/2025 Revision on: 04/16/2025 Cancelled Date: 04/16/2025 [Resident #1's] safety will be maintained through the review date. Date Initiated: 03/28/2025 Revision on: 04/16/2025 Target Date: 04/07/2025 Cancelled Date: 04/16/2025 Assess for fall risk. Date Initiated: 03/27/2025 Revision on: 04/16/2025 Cancelled Date: 04/16/2025 Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book . Date Initiated: 03/27/2025 Revision on: 04/16/2025 Cancelled Date: 04/16/2025 Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate [sic]. Date Initiated: 03/27/2025 Revision on: 04/16/2025 Cancelled Date: 04/16/2025 Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes. Date Initiated: 03/27/2025 Revision on: 04/16/2025 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Cancelled Date: 04/16/2025 WANDER ALERT: Device # Model Date Initiated: 03/27/2025 Revision on: 04/16/2025 Cancelled Date: 04/16/2025 Record review of Resident #1's Social History and Initial Assessment revealed on Page 2, Question 9. Current Behavioral Status was checked as No behavioral Concerns. The document was signed and dated by the previous Social Worker on 06/24/24. Resident #1's family member provided the information to the previous Social Worker for the Social History and Initial Assessment. Record review of the Order Summary for Resident #1 revealed a Physician Telephone Order on 01/21/2025 for WANDERGUARDS: LEFT ANKLE.CHECK FOR PLACEMENT AND PROPER WORKING FUNCTION every shift. Record review of Resident #1's MAR for January 2025 - March 2025 revealed that Resident #1's Wanderguard Checklist was marked with a check markevery day during the Day, Evening and Night Shifts and was in operable condition. The MAR did not reveal any timestamps for Resident #1's Wanderguard Checklist for the Day, Evening, and Night Shifts on 03/27/25. The MAR did not reveal any timestamps for Resident #1's Wanderguard Checklist for the Day and Evening Shifts on 03/28/25. Record review of Resident #1's Elopement Evaluation on 03/28/25 revealed, an Assessment Outcome Score of 9 indicating Resident #1 was at Risk of Elopement. Record review of Resident #1 Assessments revealed that there was not an Elopement Evaluation for him prior to 03/28/25. Record review of an email from the Administration on 05/07/25 revealed that Resident #1 only had 1 Elopement Evaluation on 03/28/25. Record review of Nurse Progress Notes from LVN A on 03/28/25 at 3:33 AM, revealed: resident was seen sitting in w/c in day area on when coming from helping another resident, he was gone down the hallway walking and pushing his w/c down by the breakroom area. then vanishes when no one seen him or heard any alarms. [Staff] begins to look for him along with nurses notified police, don, and family. resident was located across from facility ground in apartment complex. resident was brought back and evaluated with minor scratch on his chin and his left hand ring finger resident has no complaints. resident is in b/r laying down in bed resting with eyes closed with staff member doing 15 minutes check while asleep WCTM. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Nurse Progress Notes from LVN A on 03/28/25 at 3:48 PM, revealed: Elopement Evaluation: History of elopement while at home: Yes. Wandering behavior a pattern or goal-directed: Yes. Wanders aimlessly or non-goal-directed: Yes. Wandering behavior likely to affect the safety or well-being of self / others: Yes. Wandering behavior likely to affect the privacy of others: Yes. Recently admitted or readmitted (within past 30 days) and has not accepted the situation: Yes. Elopement Score: 9.0. Record review of Nurse Progress Notes from the SW's Late Entry on 03/31/25 at 12:30 PM, Effective: 03/28/25 at 12:26 PM revealed, This writer called representative to inform her of resident needing to be placed at another facility due to elopement risk. Resident representative stated she got a call from other facility regarding accepting him and I informed yes referral sent out to see if there would be anyone who would accept him. Record review of Nurse Progress Notes from CNA B's Late Entry on 03/28/25 at 13:42 [1:42 PM], Effective 03/28/25 at 12:44 PM revealed, The resident transferred to [another facility's] Secure Nursing Unit via wheelchair transport with medications and personal belongings at this time. The resident was cooperative prior to exiting the facility. No noted signs and symptoms of respiratory distress and denies discomfort prior to exiting the facility. Report called to [staff] at [another facility's] memory Care Unit. Record review of the facility's Provider Investigation Reports Fax Cover Sheet dated 04/03/25 revealed the following: Intake ID No: NO SR # received - Called in by [DON] on hotline. Record review of the facility's Provider Investigation Report revealed the following: Incident Date: 03/28/25. Time of Incident 3:20 AM. Staff reported [Resident #1], eloped from the facility to the apartment complex across the road. Record review of the facility's Provider Investigation Report's Investigation Summary section of the report reflected: [Resident #1] was brought back to the facility by the DON. Resident received treatment for his scrapes to his chin and finger. Resident placed on Q:15 minute checks. Family notified of need for secure unit and family in agreement. Facility transferred [Resident #1] to [another facility] on 03/28/2025 with resident belongings. The police department were notified about the incident. Record review of the facility's Provider Investigation Report's Facility Investigation Findings section of the report reflected: Confirmed. Record review of the facility's Provider Investigation Report's, Provider Action Taken Post-Investigation section reflected: Elopement In-Service, Wanderguard system checked with no issues identified. Record review of the facility's Provider Investigation Report's view of TULIP on 05/07/25 at 12:00 PM reflected, the wandering of Resident #1 on 03/28/25 from the facility to the apartment complex approximately100 feet across the street from the facility was not uploaded. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview on 05/05/25 at 2:25 PM, with Resident #1's family member, she stated that Resident #1 was a resident at the facility for almost 1 year. She stated that prior to Resident #1 being admitted to the facility, he was living with the family member and he had about 2-3 elopement incidents, in which a decision was made to have Resident #1 reside at a Nursing Facility. She stated that initially Resident #1 was admitted to the facility after a hospital stay, which led to him needing physical therapy. She stated that during Resident #1's stay at the facility, she realized that Resident #1 had to be at the facility long term due to his dementia and exit seeking. The family member stated that she did not initially inform the facility that Resident #1 had exit seeking behaviors and had previously eloped from home prior to being admitted to the facility. She stated that no one asked her if Resident #1 was exit seeking or had some elopement incidents while he was staying at her home. She stated that no one asked her about Resident #1's previous elopement history, therefore she did not tell them. The family member stated that Resident #1 had a Wanderguard brace on his ankle due to him exit seeking at the facility. The family member stated that on 03/28/25 at approximately 3 AM, another family member notified her via telephone informing her that their family member had exited the facility although he was wearing a Wanderguard on his ankle and was found at the apartment complex across the street attempting to climb a fence. The family member stated that the neighbor at the apartment complex across observed Resident #1 and asked him, what are you doing? Resident #1 replied, I am trying to go to work, and you can call my [family member], he will come and get me. Resident #1 provided the telephone number for his family member. The neighbor at the apartment complex across the street from the the facility, then called 911 and told them about the incident and then telephoned Resident #1's family member. According to the family member, Resident #1's other family member called the facility and notified the staff at the facility that Resident #1 was not in the facility and the staff were unaware that Resident #1 had eloped from the facility. The family member stated that the police arrived at the apartment complex across the street from the facility and returned the resident to the facility. Resident #1 was then transferred to another facility on 03/28/25, the same day of his elopement. According to the family member, Resident #1 did not receive any serious injuries from eloping from the facility. On 05/06/25 at 12:00 PM an attempt to interview the previous DON via telephone was unsuccessful. On 05/06/25 at 12:15 PM an attempt to interview LVN A via telephone was unsuccessful. On 05/06/25 at 12:17 PM an attempt to interview CNA D via telephone was unsuccessful. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the SW on 05/06/25 at 4:31, she stated that she was not at work when Resident #1 eloped from the facility on 03/28/25 due to the incident occurring around 3 AM. The SW stated that she received a telephone call during the night by the previous DON stating that during the night shift of 3/27/25 and early morning of 03/28/25. She stated that she was asleep during the original voicemail from staff and in the morning, she woke up and listened to her voicemail message. She stated that she later learned that staff noticed that Resident #1 was missing, and they looked inside the building, and he was not in the building. The SW stated that staff went to look for Resident #1 outside the facility and he was found across the street at an apartment complex. The SW stated that Resident #1 had a Wanderguard on his leg and was exit seeking according to staff but had never exited the facility prior to the incident when he eloped on 03/28/25. The SW stated that according to the staff's records for Resident #1 had a Wanderguard Test on on 03/27/25 and 03/28/25 and it was working properly. She stated that staff sent an alert made for Resident #1 due to his eloping from the facility and then the staff began looking for him She stated that the facility was not aware that the resident had any elopement issues. She stated that if the facility was informed during Pre-Admission that any resident had any previous elopement issues, the facility would have not admitted that person to the facility. She stated that there are not any Power of Attorneys on file for Resident #1 and he was his own RP. The SW stated that she and staff were In-Serviced on Abuse, Neglect and Elopement Procedures and Guidelines after the incident involving Resident #1 eloping from the facility. In an interview with the Administrator on 05/06/25 at 4:53 PM, she stated that she was on vacation when Resident #1 eloped from the facility during the evening shift on 03/28/25. She stated that she is the Abuse Coordinator for the facility and when she returned to work at the facility, the previous DON updated her on the situation involving Resident #1's elopement on 03/28/25. The Administrator stated that the previous DON told her that Resident #1 exited the facility using the front door and was found across the street at an apartment complex. She stated that a man that lived in the apartment complex across the street witnessed him and law enforcement was notified. The previous DON went across the street to get Resident #1 and brought him back to the facility. She stated that Resident #1 did not have any serious injuries according to his head to toe assessment that was given by LVN A. She stated that Resident #1 was placed on 1:1 observation, (a healthcare practice where a staff member provides continuous, one-to-one attention to a patient), after the incident and a staff member was always with him. She stated that the previous DON stayed with Resident #1 until the next shift began at 6 AM. The Administrator stated that Resident #1's Emergency Contacts, Doctor and Behavioral Health were notified of Resident #1's elopement. She reported that Resident #1 had been at the facility for approximately 1 year and there was not any previous history of Resident #1 having any elopement issues or concerns prior to him being admitted to the facility. She stated that if the facility learned that Resident #1 was exit seeking or had any prior elopement concerns, he would not have been admitted to the facility because the facility is not equipped to have a Secured Unit. She stated that the SW then began to find placement for Resident #1 at a facility that had a Secure Unit. She stated that Resident #1 was discharged to another facility with a Secured Unit on 03/28/25. She stated that Resident #1 had a Wanderguard per his doctor's order and his Wanderguard was tested 3 times a day, per his doctor's orders. She stated that no one knows how Resident #1 was able to exit the facility on 03/28/25 due to his Wanderguard and the exterior doors working in proper order. She stated that the staff were In-Serviced on abuse, neglect, and elopement procedures after Resident #1's elopement form the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the Maintenance Supervisor on 05/06/25 at 5:45 PM, he stated that he had been employed at the facility since 04/12/25. He stated that he was not aware of the elopement incident on 03/28/25 by Resident #1. He stated that there was not any documentation showing that there were any issues with any of the exterior doors at the facility on 03/27/25 and 03/28/25. He stated that he does daily checks on all the doors in the facility. He stated that the exterior doors to the building have a fire alarm and will alert if they are opened. He stated that the front door of the facility will alert and made a ringing sound if a resident with a Wanderguard attempts to exit the front door. He stated that he and other facility staff regularly receive In-Service Trainings on Abuse, Neglect and Elopement Procedures and Protocols. In an interview with CNA C on 05/07/25 at 10:44 AM, she stated that she had been employed at the facility for 1 year. She stated that she was not at the facility on 03/28/25 due to being off duty. She stated that Resident #1 had dementia and during her shifts was observed coming close to the side door on his hallway. She stated that he had not observed Resident #1 exit any doors from the facility. She stated that when she returned to work, she was informed by staff that Resident #1 had exited the building during the night shift on 03/27/25 - 03/28/25. She stated that the night shift duty hours are 10 PM - 6 AM. She stated that Resident #1 did not receive any serious injuries according to his skin assessment on 03/28/25. She stated that all staff receive trainings throughout each week on abuse, neglect, and elopement. She stated that she remembered that she received an In-Service Training on Elopement after the incident on 03/28/25 when Resident #1 eloped from the facility. On 05/07/25 at 11:16 AM an attempt to interview LVN A via telephone was unsuccessful. On 05/07/25 at 11:18 AM an attempt to interview CNA D via telephone was unsuccessful. This was determined to be a Past Non-Compliance Immediate Jeopardy on 05/07/25 at 2:50 PM. The Administrator was notified. The Administrator was provided with the IJ template via email on 05/07/25 at 2:57 PM. The facility took the following actions to correct the non-compliance prior to the investigation: Record review of the facility's In-Service Trainings revealed that all staff were in-serviced on the facility's abuse, neglect and elopement policies and procedures, elopement, risk assessments, skin assessments, notification to PCP and RP on 04/01/25. Record review of the facility's In-Service Trainings revealed all staff were in-serviced on the facility's abuse and neglect and policies and procedures on 04/23/25. The In-Service Training paperwork states, All staff if you see or suspect any forms of abuse/neglect towards a resident immediately remove the resident/report to the abuse coordinator [Administrator]. On 05/07/25 at 3:00 PM an observation was made of Resident #2 with a Wanderguard exiting the front door. Resident #2's Wanderguard was operating properly and there was an alarm that sounded. Staff in the Office were able to hear the alarm and staff at the Nurses Station were able to hear the alarm. The Staff in the Administration Offices at the front of the facility were observed walking towards the front door of the facility when the alarm sounded. The Staff on the hallways were observed walking towards each fire door after the fire alarm sounded. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview and observation on 05/07/25 at 3:14 PM, the Maintenance Director stated he was not present at the time of Resident #1's elopement and could not state whether or not a door alarm sounded. The Maintenance Director was observed opening the interior fire exit doors on the hallways throughout the facility and the front door. The fire alarms alerted each time the Maintenance Director opened each door. The fire alarms could be heard by staff throughout the building. The Staff at both Nurses Stations and on the hallways stated that there were able to her the fire alarms from their locations. Record review of the facility's Resident Rights policy dated, December 2024 revealed: Policy Statement: Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; . b. be free from abuse, neglect . Record review of the facility's Elopements policy dated, December 2024 revealed: Policy Statement: Staff shall investigate and report all cases of missing residents. Policy Interpretation and Implementation: . 3. When a departing individual returns to the facility, the Director of Nursing Services or Charge Nurse shall: c. Notify the resident's legal representative (sponsor) of the incident; d. Complete and file Report of Incident/Accident; and e. Document the event in the resident's medical record. 4. If an employee discovers that a resident is missing from the facility, he/she shall: b. If the resident was not authorized to leave, initiate a search of the building(s) and premises, c. If the resident is not located, notify the Administrator and Director of Nursing Services, the resident's legal representative . 5. When the resident returns to the facility, the Director of Nursing Services or Charge Nurse shall: c. Notify the resident's legal representative; . (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	e. Complete and file an incident report and self-report to your regulatory agency; and f. Document relevant information in the resident's medical record. The facility's Elopements Policy did not include any information regarding Supervision, Accidents and Preventing Elopements.