STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675857	A. Building B. Wing	03/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
William R Courtney Texas State Veterans Home	1424 Martin Luther King Jr LN Temple, TX 76504

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47065 Based on interviews and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 (Resident #1) of 12 residents reviewed for elopement. The facility failed to ensure staff assessed Resident #1 after finding him at a hotel on 03/16/25 after he eloped from the facility on 03/15/25. This failure could place residents at risk of changes in condition not being treated. Findings included: Review of Resident #1's Admission Record, dated 03/21/25, reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, unspecified dementia, depression, and unsteadiness on feet. Review of Resident #1's Admission and Modified MDS Assessments, dated 12/25/24, reflected he had a BIMS score of 12, which indicated he had moderate cognitive impairment. Resident #1 required supervision with toileting, bathing, dressing, and transferring, set-up assistance with personal and oral hygiene, and was independent with eating and repositioning. Review of Resident #1's Care Plan, dated 01/01/25, reflected he was exit-seeking and at risk for elopement and/or wandering with unsafe boundaries related to his dementia. Resident #1 was also at risk for falls related to his unsteady gait, poor balance, history of falls, osteoarthritis, and dementia. Review of Resident #1's Progress Notes reflected there were no notes from 02/21/25 through 03/15/25. The progress notes also reflected: (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A note by LVN A on 03/16/25 at 6:01 a.m., This nurse was notified by CNA's at approx. 2130 (9:30 p.m.) that resident had not been seen since the beginning of the shift. We began searching his regular spots, like the library and dining room. When we couldn't locate him, RN supervisor was informed and she notified DON and administrator. Family was notified and Police and PD were also informed and responded to the incident. Every hall was instructed to check every room, bathroom, closet and office. The perimeter of the building was searched and Police searched the entire property by their patrol vehicles. DON and administrator were informed and administrator arrived to the facility to aid in the investigation. PD was informed and also arrived on scene to obtain more information about resident's appearance and other pertinent information. Family was informed and kept updated throughout the shift. -A note by the DON on 03/16/25 at 8:26 a.m., Notified by CNAs on duty that resident was not located in room upon rounds. Staff immediately initiated room search which then extended to entire community and campus without identifying resident's location. Said nurse immediately called Administrator, Police and PD to inform of possible missing person. PD onsite and additional details were provided. Family reported that resident has previously done this before and to notify them if resident's whereabouts are identified. Resident confirmed that he left the community yesterday evening with the intention of not returning. Resident is A&O x 4 and verbalized his plans of moving from the area to Oklahoma where he has friends. Resident was asked why he failed to alert the staff of his intentions and resident replied that he chose not to alert staff because he thought that the staff would not allow him to leave the facility. Resident reports that he is not happy with his family and does not want his family making his decisions. Resident has communicated that he is capable of making his own decisions and intends on doing so. Resident is in a local hotel room and reports that his plan continues to be to go to a friend's home and ultimately plans to move to Oklahoma. He stated that may consider a community in Oklahoma or wants his own apartment. He also reported that he is going to store tomorrow to get a phone, but for now he will remain at his hotel. Resident was informed that his PCP has provided orders that he is discharged from community AMA and that his medications will be released to him and that a nurse will review the medications with him as recommended and that Home Health will be referred if he is agreeable. Resident was informed that out of an abundance of caution community will refer to APS for wellness checks as well as possible assistance that he may need for relocating since resident is not agreeable to remain in the facility. Resident was informed that any additional belongings he may have in the community will also be brought to him at the hotel along with his medications and that in good faith the community is going to have a nurse review his medications with him to ensure he is able to properly administer and that we strongly recommend that he allow home health services. Despite education and resident has been discharged AMA at his request. Community will adhere to MD's recommendations for home health referral and out of an abundance of caution SW will notify APS for a wellness check and any additional support that resident may need. -A Late Entry note by the SW on 03/16/25 10:00 a.m., SW was notified that resident expressed a desire to no longer reside at facility. SW was asked to bring the AMA waiver to resident's location. The waiver was signed by resident, with a nurse serving as the witness. SW conducted a Brief Interview for Mental Status exam with resident, scoring 9. Additionally, SW provided information regarding a nursing home in Oklahoma, which resident expressed interest in. Upon returning to facility, SW immediately called APS to report resident leaving AMA. There were no notes related to assessing Resident #1 post-elopement. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Hotel Registration, printed on 03/15/25 at 2:14 p.m., reflected Resident #1's arrived at the hotel on 03/15/25 and signed his checked in in-person. Review of the facility's Provider Investigation Report reflected the RN Supervisor notified the facility on 03/16/25 that on 03/16/25 at 12:30 a.m., Resident #1 was not present in his room. There were no witnesses. Investigation Summary reflected, At approximately 9:45 p.m., CNAs reported to their charge nurse that they last recalled seeing Resident #1 on 03/15/25 around 6:30 p.m. The charge nurse promptly informed the RN Supervisor, who prompted the team to initiate an initial search. The facility conducted a search of the entire community and immediate area outside the community and could not locate Resident #1. On 03/16/25 at approximately 12:30 a.m., the RN Supervisor notified the ADM, DON, and police. During this process, the RN Supervisor discovered an itinerary in the copy room containing various pertinent details, including information regarding a train company, cab company, hotel, and bank. This information was communicated to the ADM and responding police officer upon their arrival on-site. The search efforts were then expanded within the community by reaching out to the contacts and businesses listed on the itinerary. The ADM first contacted the hotel at approximately 2:00 a.m., only to be informed that Resident #1 was not present there. However, later that morning, the memory care director contacted the hotel again and was informed that Resident #1 was indeed at the hotel. In response, the memory care director, accompanied by another team member and a social worker, proceeded to the hotel to retrieve Resident #1. An assessment was conducted, and attempts were made to persuade Resident #1 to return to the community; however, Resident #1 declined. Resident #1 who has a BIMS of 12 and when assessed by the charge nurse on site shared, he is alert and oriented x4, explained that he had intentionally departed from the community without signing out or notifying his nurse, as he believed the nurse would not support his desire to visit a friend. He expressed plans to continue to a friend's home in Oklahoma, where he preferred to be. Resident #1 was subsequently informed that should he choose not to return, he would need to sign out of the community AMA, which he proceeded to do. One of the team members then returned to the community to collect all of his medications and APS was notified. Additionally, his family was informed that he had been located and was safe. The following morning, the community dispatched a charge nurse back to Resident #1's hotel room to conduct a health and welfare check, ensuring that he remained safe, alert, and oriented. Upon this visit, it was confirmed that he was indeed safe, alert, and oriented, and his family had arrived at the hotel. The facility's investigation findings were unfounded. The elopement response in-service given to staff by unknown on unknown date did not reflect assessing residents after locating them. The facility's response plan did not reflect assessing residents after locating them. There were no assessments on Resident #1 included with the report. Review of Resident #1's BIMS Evaluation, dated 03/16/25 at 1:46 p.m. by SW, reflected he had a BIMS of 9, which indicated his cognitive status declined since his admission. Review of Resident #1's Assessments, dated 03/21/25, reflected there were no other assessments on 03/16/25 other than the SW's BIMS discharge evaluation on 03/16/25. Review of Resident #1's vitals, dated 03/21/25, reflected there were no vitals taken on 03/16/25. During an interview on 03/21/25 at 11:40 a.m., the ADM stated Resident #1 discharged from the facility and could not recall the exact date. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/21/25 at 11:49 a.m., Resident #1's FAM stated LVN G called and notified them on 03/15/25 around 10:30 p.m. that they could not locate Resident #1 and Resident #1 was last observed lying in his bed in his room on 03/15/25 around 6:30 p.m. The FAM stated the ADM called and notified them on 03/16/25 at 12:46 p.m. Resident #1 was found at a hotel, did not want to return to the facility, they conducted a BIMS exam, and allowed him to sign himself out AMA. The FAM stated Resident #1 told them that he fell in the shower at the hotel and scraped his knee on 03/16/25. The FAM stated Resident #1 was a high fall risk, diagnosed with dementia in 2023, and was in denial about his dementia and limitations. The FAM stated they took Resident #1 to the hospital because they believed he was not evaluated. During an interview on 03/21/25 at 2:16 p.m., Resident #1 stated staff last checked on him on 03/15/25 around 7:00 a.m., he ate breakfast in his room around 8:00 a.m., walked out the facility's front door around 11:00 a.m., and did not return. Resident #1 stated he left the facility because the facility ran out of tissue paper. Resident #1 stated he walked for two hours to a store (approximately 2.8 miles from the facility), got a ride at some point to the store, got another ride to the hotel, and arrived at the hotel (approximately 10 miles from the store) around 3:00 p.m.-4:00 p.m. Resident #1 stated he lost his balance, fell , and hit his shin while taking a shower at the hotel on the morning of 03/16/25. Resident #1 stated he often fell before his admission to the facility and never fell during his admission at the facility. Resident #1 stated the facility staff found him at the hotel on 03/16/25 around 11:00 a.m. Resident #1 stated staff did not assess him. Resident #1 stated the SW had him sign an AMA form after he told the facility staff that he did not want to return to the facility. Resident #1 stated his FAM were his POAs and the facility typically notified his FAM for decisions about his care. Resident #1 stated he went to the hospital from 03/17/25 through 03/21/25 and did not know why he was kept at the hospital. During an interview on 03/21/25 at 2:38 p.m., Resident #1's FAM stated Resident #1 stayed at the hospital from 03/17/25 through 03/21/25 because he was being transferred to another facility with a wander guard system. During an interview on 03/21/25 at 3:09 p.m., the NP stated Resident #1 had dementia, history of elopement, and wore a wander guard. The NP stated she did not know if Resident #1 had a history of falls, if he had the capacity to make informed decisions for himself, and if it was safe for him to be out alone without supervision because he had mild dementia and was taking medications to slow down dementia progression. The NP stated she expected staff to assess resident's post-elopement for any changes in condition. During an interview on 03/22/25 at 9:34 a.m., RN F stated she knew to assess a resident after an elopement. RN F stated she knew the importance of assessing resident's post-elopement and said, Because residents could have had a change in condition or a fall when they were missing. During an interview on 03/22/25 at 10:14 a.m., LVN H stated nurses assessed residents after an elopement to ensure nothing occurred while they were missing. LVN H stated she knew the importance of assessing resident's post-elopement and said, Because how do we know what happened to the resident if we don't assess and follow-up to make sure resident was okay. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/22/25 at 2:05 p.m., the RN Supervisor stated nurses performed a head-to-toe assessment on a resident after an elopement. The RN Supervisor stated she knew the importance of assessing resident's post-elopement and said, Residents could have fallen and sustained a fracture or bruises or different things or could have been sexually or physically assaulted, which was why we assess them. During an interview on 03/22/25 at 2:35 p.m., LVN A stated nurses were required to conduct an elopement risk assessment and basic head to toe assessment to make sure a resident did not fall or get injured after an elopement. LVN A stated she knew the importance of assessing resident's post-elopement and said, Because they could have fallen or hurt themselves while they were missing. Residents could have repercussions from any injuries they sustained while missing. During an interview on 03/22/25 at 4:33 p.m., LVN G stated nurses were required to conduct a head-to-toe assessment on a missing resident after an elopement. LVN G stated she knew the importance of assessing resident's post-elopement and said, Because a resident might not know if they were injured and because staff did not know what they ate and drank and they need to know if the resident was still at baseline. During an interview on 03/22/25 at 6:48 p.m. the Memory Care Director stated she reviewed Resident #1's itinerary, called the hotel listed on his itinerary, learned he was at the hotel, and her and the SW went to the hotel on 03/16/25. The Memory Care Director stated she conducted a head-to-toe assessment on Resident #1 to determine if he had any changes in condition on 03/16/25. The Memory Care Director stated Resident #1 did not have any bruises or changes in condition. The Memory Care Director stated she did not know Resident #1 fell in the hotel shower while he was missing. The Memory Care Director stated she did not document the assessment in Resident #1's electronic health records and documented the assessment in her statement included in the facility's Provider Investigation Report. The Memory Care Director stated she knew the importance of assessing resident's post-elopement and said, Because residents could have been in danger, and we don't know what happened to the resident when they were missing. During an interview on 03/22/25 at 7:57 p.m., the ADM stated the RN Supervisor notified him on 03/16/25 around 12:10 a.m. and 12:15 a.m. that the unknown name CNAs last observed Resident #1 on 03/15/25 around 6:30 p.m. and observed Resident #1's lunch tray was still in his room around 9:00 p.m. The ADM stated the Memory Care Director reviewed an itinerary Resident #1 made at the facility and found out Resident #1 was at a hotel on 03/16/25. The ADM stated the Memory Care Director, and the SW went to the hotel and found Resident #1. The ADM stated the Memory Care Director conducted a head-to-toe assessment on Resident #1 and believed she documented the assessment, and the DON could confirm. The ADM stated Resident #1 did not have any injuries. The ADM stated he expected residents to be immediately assessed following an incident. The ADM stated he knew the importance of assessing residents after an incident and said, Because it could be a negative outcome and residents could die. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/22/25 at 8:34 p.m., the DON stated the ADM called and notified him on 03/15/25 around 11:00 p.m. that Resident #1 was missing. The DON stated the Memory Care Director notified him on 03/16/25 that Resident #1 was at a hotel. The DON stated the Memory Care Director, and the police went to the hotel. The Memory Care Director conducted a visual nurse assessment on Resident #1 and ensured he was alert and oriented. The DON stated he was unsure if the Memory Care Director conducted a head-to-toe assessment on Resident #1. The DON stated he expected the Memory Care Director to conduct the assessment on Resident #1, if Resident #1 allowed her, and knew at the time that Resident #1 was agitated. The DON stated he was not aware that Resident #1 had a fall while he was missing. The DON stated nurses would typically assess a resident upon finding them . Review of the facility's Missing Resident/Elopement policy, revised 05/23/22, reflected: When an elopement occurs: After the resident has been found, complete a thorough evaluation of resident's physical condition and psychosocial wellbeing. Provide medical intervention as needed. Review of the facility's Elopement Response and Exit Seeking Management policy, revised January 2023, reflected: B. Response following the location of the resident: Once located and safety confirmed, conduct an assessment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47065 Based on interviews and record review, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 1 (Resident #1) of 12 residents reviewed for elopement. 1. The facility failed to ensure Resident #1's wander guard bracelet was secured on his wrist so he could not remove it before he eloped from the facility on 03/15/25. 2. The facility failed to ensure staff noticed Resident #1 was missing until approximately 11 hours after he left the faciity on [DATE]. An IJ was identified on 03/21/25. The IJ template was provided to the facility on [DATE] at 4:57 p.m. While the IJ was removed on 03/22/25, the facility remained out of compliance at a scope of isolated and a severity of potential for more than minimal harm because of the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of not receiving adequate supervision, injury, and death. Findings included: Review of Resident #1's Admission Record, dated 03/21/25, reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, unspecified dementia, depression, and unsteadiness on feet. Resident #1 had an MPOA and FPOA, which were his responsible parties. Review of Resident #1's Admission and Modified MDS Assessments, dated 12/25/24, reflected he had a BIMS score of 12, which indicated he had moderate cognitive impairment. Resident #1 used a wander/elopement alarm daily. Resident #1 required supervision with toileting, bathing, dressing, and transferring, set-up assistance with personal and oral hygiene, and was independent with eating and repositioning. Review of Resident #1's Admission Assessment, dated 03/21/25, reflected he was a high risk for elopement and had on one or more occasions attempted to exit or had exited the facility. Review of Resident #1's Care Plan, dated 01/01/25, reflected he was exit-seeking and at risk for elopement and/or wandering with unsafe boundaries related to his dementia. Resident #1 was also at risk for falls related to his unsteady gait, poor balance, history of falls, osteoarthritis, and dementia. Review of Resident #1's Order Summary Report, dated 03/21/25, reflected he had the following active orders: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Check Functionality of the Wander Guard/Alert Device: may use system check wand or use door alarm to confirm functionality every shift for Wandering/Exit Seeking related to Alzheimer's disease ordered and started on 12/19/24 -Check placement of wander guard/roam alert on (left wrist). Document N = Not present/Not in place - replace and document in progress notes. Y - Yes, Present/in place (Add N/Y to supplementary documentation) every shift for Wandering/Exit Seeking related to Alzheimer's disease ordered and started on 12/19/24 Review of Resident #1's Psychological Services Progress Note, dated 02/28/25, reflected, Patient reported some increase in depression. He stated that he has been rethinking his feelings about nursing home placement because he is realizing that he is not going to be able to do some of the things he wants to do .Patient continues to appear impulsive and somewhat grandiose and unrealistic in his thinking. Another Psychological Services Progress Note also reflected he could travel outside the home only when accompanied and supervised. Review of Resident #1's Hotel Registration, printed on 03/15/25 at 2:14 p.m., reflected Resident #1's arrived at the hotel on 03/15/25 and signed his check in registration in-person. Review of Resident #1's Progress Notes reflected there were no notes from 02/21/25 through 03/15/25. The progress notes also reflected: -A note by LVN A on 03/16/25 at 6:01 a.m., This nurse was notified by CNA's at approx. 2130 (9:30 p.m.) that resident had not been seen since the beginning of the shift. We began searching his regular spots, like the library and dining room. When we couldn't locate him, RN supervisor was informed and she notified DON and administrator. Family was notified and Police and PD were also informed and responded to the incident. Every hall was instructed to check every room, bathroom, closet and office. The perimeter of the building was searched and Police searched the entire property by their patrol vehicles. DON and administrator were informed and administrator arrived to the facility to aid in the investigation. PD was informed and also arrived on scene to obtain more information about resident's appearance and other pertinent information. Family was informed and kept updated throughout the shift. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-A note by the DON on 03/16/25 at 8:26 a.m., Notified by CNAs on duty that resident was not located in room upon rounds. Staff immediately initiated room search which then extended to entire community and campus without identifying resident's location. Said nurse immediately called Administrator, Police and PD to inform of possible missing person. PD onsite and additional details were provided. Family reported that resident has previously done this before and to notify them if resident's whereabouts are identified. Resident confirmed that he left the community yesterday evening with the intention of not returning. Resident is A&O x 4 and verbalized his plans of moving from the area to Oklahoma where he has friends. Resident was asked why he failed to alert the staff of his intentions and resident replied that he chose not to alert staff because he thought that the staff would not allow him to leave the facility. Resident reports that he is not happy with his family and does not want his family making his decisions. Resident has communicated that he is capable of making his own decisions and intends on doing so. Resident is in a local hotel room and reports that his plan continues to be to go to a friend's home and ultimately plans to move to Oklahoma. He stated that may consider a community in Oklahoma or wants his own apartment. He also reported that he is going to store tomorrow to get a phone, but for now he will remain at his hotel. Resident was informed that his PCP has provided orders that he is discharged from community AMA and that his medications will be released to him and that a nurse will review the medications with him as recommended and that Home Health will be referred if he is agreeable. Resident was informed that out of an abundance of caution community will refer to APS for wellness checks as well as possible assistance that he may need for relocating since resident is not agreeable to remain in the facility. Resident was informed that any additional belongings he may have in the community will also be brought to him at the hotel along with his medications and that in good faith the community is going to have a nurse review his medications with him to ensure he is able to properly administer and that we strongly recommend that he allow home health services. Despite education and resident has been discharged AMA at his request. Community will adhere to MD's recommendations for home health referral and out of an abundance of caution SW will notify APS for a wellness check and any additional support that resident may need. -A Late Entry note by the SW on 03/16/25 10:00 a.m., SW was notified that resident expressed a desire to no longer reside at facility. SW was asked to bring the AMA waiver to resident's location. The waiver was signed by resident, with a nurse serving as the witness. SW conducted a Brief Interview for Mental Status exam with resident, scoring 9. Additionally, SW provided information regarding a nursing home in Oklahoma, which resident expressed interest in. Upon returning to facility, SW immediately called APS to report resident leaving AMA. Review of Resident #1's BIMS Evaluation, dated 03/16/25 at 1:46 p.m. by SW, reflected he had a BIMS of 9, which indicated his cognitive status declined since his admission. Review of Resident #1's AMA Waiver, dated 03/16/25 12:25 p.m., reflected Resident #1 reviewed and signed the waiver with LVN B. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's Provider Investigation Report reflected the RN Supervisor notified the facility on 03/16/25 that on 03/16/25 at 12:30 a.m., Resident #1 was not present in his room. There were no witnesses. Investigation Summary reflected, At approximately 9:45 p.m., CNAs reported to their charge nurse that they last recalled seeing Resident #1 on 03/15/25 around 6:30 p.m. The charge nurse promptly informed the RN Supervisor, who prompted the team to initiate an initial search. The facility conducted a search of the entire community and immediate area outside the community and could not locate Resident #1. On 03/16/25 at approximately 12:30 a.m., the RN Supervisor notified the ADM, DON, and police. During this process, the RN Supervisor discovered an itinerary in the copy room containing various pertinent details, including information regarding a train company, cab company, hotel, and bank. This information was communicated to the ADM and responding police officer upon their arrival on-site. The search efforts were then expanded within the community by reaching out to the contacts and businesses listed on the itinerary. The ADM first contacted the hotel at approximately 2:00 a.m., only to be informed that Resident #1 was not present there. However, later that morning, the memory care director contacted the hotel again and was informed that Resident #1 was indeed at the hotel. In response, the memory care director, accompanied by another team member and a social worker, proceeded to the hotel to retrieve Resident #1. An assessment was conducted, and attempts were made to persuade Resident #1 to return to the community; however, Resident #1 declined. Resident #1 who has a BIMS of 12 and when assessed by the charge nurse on site shared, he is alert and oriented x4, explained that he had intentionally departed from the community without signing out or notifying his nurse, as he believed the nurse would not support his desire to visit a friend. He expressed plans to continue to a friend's home in Oklahoma, where he preferred to be. Resident #1 was subsequently informed that should he choose not to return, he would need to sign out of the community AMA, which he proceeded to do. One of the team members then returned to the community to collect all of his medications and APS was notified. Additionally, his family was informed that he had been located and was safe. The following morning, the community dispatched a charge nurse back to Resident #1's hotel room to conduct a health and welfare check, ensuring that he remained safe, alert, and oriented. Upon this visit, it was confirmed that he was indeed safe, alert, and oriented, and his family had arrived at the hotel. The facility's investigation findings were unfounded. Staff were in-serviced on elopement response on unknown date by unknown person, abuse and neglect reporting on unknown date by the DON, and medication administration documentation on unknown date by the DON. There were no in-services related to checking residents' wander guard devices to ensure functionality and placement. During facility's immediate response, staff identified Resident #1's exit seeking device was removed and left within the community. There were no immediate, risk, system, and monitoring response interventions related to checking and ensuring all other residents' wander guard devices and wander guard alarm system were functional and in place. Staff statements reflected CNA C observed Resident #1 on 03/15/25 in the early afternoon, CNA D observed Resident #1 around 3:00 p.m., CNA F observed Resident #1 lying in his bed around 5:45 p.m., CNA E observed Resident #1 lying in his bed around 6:00 p.m., LVN A observed Resident #1 lying in his bed at approximately 6:20 p.m., the RN Supervisor was notified by LVN A that Resident #1 was missing at approximately 10:00 p.m., and the Memory Care Director called and found Resident #1 at a hotel on unknown date. During an interview on 03/21/25 at 11:40 a.m., the ADM stated Resident #1 was discharged from the facility. The ADM stated he could not recall the exact discharge date . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/21/25 at 11:49 a.m., Resident #1's FAM stated Resident #1 wore a wander guard device at the facility. FAM stated LVN G called and told them on 03/15/25 at 10:30 p.m. the facility staff were unable to locate and were searching for Resident #1. The FAM stated LVN G called and told them on 03/16/25 at 12:00 a.m. that Resident #1 was last seen lying in his bed in his room on 03/15/25 at 6:30 p.m. The FAM stated on 03/16/25 at 12:46 p.m., the ADM called and told them Resident #1 was found at a hotel, did not want to return to the facility, staff conducted a BIMS evaluation, and allowed Resident #1 to sign himself out AMA. The FAM stated Resident #1 told them he was able to take off the wander guard device on his own, had taken off his wander guard device, and placed it in his dresser one month ago (February 2025). The FAM stated Resident #1 told them he left the facility through the front door, and they did not know if anyone observed Resident #1 leave the facility. The FAM stated Resident #1 told them he got a ride to the hotel by giving his walker to some strangers. The FAM stated Resident #1 told them he fell in the hotel shower and scraped his knee. The FAM stated Resident #1 was in denial about his dementia, limitations, and was a high fall risk. The FAM stated they took Resident #1 to the hospital on 03/17/25 to be evaluated because they believed the facility did not evaluate him. During an interview on 03/21/25 at 2:16 p.m., Resident #1 stated he took off his wander guard device one month ago and staff did not notice him not wearing it since he took it off. Resident #1 stated staff last checked on him on 03/15/25 around 7:00 a.m., he ate breakfast in his room around 8:00 a.m., walked out the facility's front door around 11:00 a.m., and did not return. Resident #1 stated no one observed him walk out the facility's front door because the receptionist and staff were all on a break and not present. Resident #1 stated he did not tell anyone that he left the facility because it was nobody's business, and he did not want to return to the facility. Resident #1 stated he left the facility because the facility ran out of tissue paper. Resident #1 stated he walked for two hours to a store (approximately 2.8 miles from the facility), got a ride at some point to the store, got another ride to the hotel, and arrived at the hotel (approximately 10 miles from the store) around 3:00 p.m.-4:00 p.m. Resident #1 stated he lost his balance, fell , and hit his shin while taking a shower at the hotel on the morning of 03/16/25. Resident #1 stated he often fell before his admission to the facility. Resident #1 stated the facility staff found him at the hotel on 03/16/25 around 11:00 a.m. Resident #1 stated the SW had him sign an AMA after he told the facility staff he did not want to return to the facility. Resident #1 stated his FAM were his POAs and the facility typically notified his FAM for decisions about his care. Resident #1 stated he went to the hospital from 03/17/25 through 03/21/25 and did not know why he was kept at the hospital. An attempt to call and interview the MD was made on 03/21/25 at 3:08 p.m. The phone number provided was a general phone number. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/21/25 at 3:09 p.m., the NP stated she expected CNAs and nurses to make hourly rounds on the residents. The NP defined elopement as someone attempting to leave and was deemed as not being safe to be on their own. The NP stated she did not know Resident #1 was an elopement risk. The NP stated Resident #1 had dementia, history of elopement, and wore a wander guard device. The NP stated she did not know if it was safe for Resident #1 to be out alone without supervision because he had mild dementia and took medications to slow down his dementia progression. The NP stated the wander guard alarm rang if a resident tried to leave the facility. The NP stated she did not know how often the wander guard was required to be checked. The NP stated she expected the nurses to check residents' wander guard devices daily, notify her if a resident took off the wander guard device and said, Because it's for safety. The NP stated she knew the importance of checking residents' wander guard devices and said, It was a device used to determine if a resident left the facility unsupervised. It's a safety issue. It's not supposed to be easy to take off a wander guard. The wander guards were supposed to be placed securely around residents' ankles or wrists. During an interview on 03/22/25 at 9:34 a.m., RN F stated CNAs and nurses were responsible for checking on residents every two hours. RN F stated she defined elopement as when a resident left the facility or locked unit. RN F stated residents' wander guards were to be checked daily and placed on a resident's right arm. RN F stated she never observed a resident take of their wander guard and believed residents could find a way of taking off their wander guard. RN F stated she knew the importance of checking residents' wander guard devices and said, To ensure safety and make sure the resident was able to use it and make sure the alarm worked. I'm sure there were some that would try and take it off. Residents could go any number of places, walk out in the street, and be injured or taken any numbers of ways and unimaginable things. During an interview on 03/22/25 at 10:04 a.m., CNA G stated she checked on residents every hour. CNA G stated she knew the importance of checking on residents and said, To know where resident was and to prevent falls. CNA G stated she defined elopement as a resident getting out of the facility. CNA G stated she would search for the resident if a resident was missing and notify the nurse if she could not find the resident. CNA G stated CNAs and nurses checked residents' wander guards and ensured the wander guards were functioning and in place daily. During an interview on 03/22/25 at 10:14 a.m., LVN H stated CNAs and nurses were required to check on residents every two hours. LVN H stated she defined elopement as a resident leaving the facility and was unable to be found without anyone knowing. LVN H stated nurses were responsible for checking residents' wander guard devices and ensuring they were functioning and in place. LVN H stated she knew the importance of checking residents' wander guard devices and said, Residents could go missing, and staff could just not know that residents were outside. During an interview on 03/22/25 at 10:31 a.m., CNA I stated CNAs and nurses were responsible for checking on residents every 15 or 20 minutes. CNA I stated she could not define elopement because she did not know what it meant. CNA I stated she would immediately notify a nurse and search for the resident if a resident was missing and she was unable to locate the resident. CNA I stated she was unsure who was responsible for checking residents' wander guard devices to ensure they were functioning and in place. CNA I stated she knew the importance of checking residents' wander guard devices and said, Just in case a resident took off, to make sure the wander guard alarm goes off, residents don't walk out the building and get lost, and so we wouldn't know they were gone because it could be devastating. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/22/25 at 10:51 a.m., the Memory Care Director stated CNAs and nurses checked on residents every two hours. The Memory Care Director stated she defined elopement as someone leaving the facility. The Memory Care Director stated she would look for the resident if a resident was not in their room and notify the DON and the ADM if the resident was still missing. The Memory Care Director stated nurses checked residents' wander guard devices to make sure they were functioning and in place. The Memory Care Director stated she knew the importance of checking the wander guard devices and said, So you know if a resident left and could locate the resident. The resident could disappear, and no one could know where they were at. During an interview on 03/22/25 at 11:02 a.m., CNA J stated CNAs and nurses checked on residents every 30 minutes. CNA J stated she knew the importance of checking on residents and said, Because a resident could go missing or fall. CNA J stated she would locate a resident and notify the nurse if she could not find a resident. CNA J stated CNAs and nurses were responsible for checking residents' wander guard devices. CNA J stated she knew the importance of checking residents' wander guard devices and said, If we don't, residents will wander out the doors. Very important. During an interview on 03/22/25 at 11:14 a.m., the MS stated the RN Supervisor called and notified him on 03/16/25 around 12:45 a.m.-12:50 a.m. that Resident #1 eloped from the facility and there was damage to an exit door on Resident #1's hall. The MS stated the ADM called and notified him on 03/16/25 at 12:52 a.m. that Resident #1 broke off the facility's back door wander guard alarm plate and removed the battery. The MS stated he visited the facility on 03/16/25 and observed a paperclip, screw, and wander guard alarm system cover stored in a fire extinguisher box near the exit door on Resident #1's hall. The MS stated he checked the wander guard alarm system daily and did not document the daily inspections before Resident #1's incident. The MS stated he repaired the exit door, verified the wander guard alarm system on the door was operable, and provided a wander guard tester to staff after Resident #1's incident. The MS stated he and the nurses checked residents' wander guard devices to ensure they were functioning. The MS stated the nurses checked residents' wander guard devices to ensure they were in place. The MS stated he checked the facility's exit doors and computers to ensure residents' wander guard devices were functioning and notified the DON whenever they were inoperable. The MS stated residents required assistance with taking off their wander guard devices. The MS stated he never observed a resident take off their wander guard device by themself. The MS stated he knew the importance of checking residents' wander guard devices and said, Because it's for the safety of the resident. Residents could get out, get hurt, get struck, and could pass away. During an interview on 03/22/25 at 1:15 p.m., CNA K stated she frequently checked on residents and could not clarify on what she meant by frequent. CNA K stated CNAs and nurses checked on residents every two hours. CNA K stated she knew the importance of checking on residents and said, To make sure everyone was alive, and wellbeing was okay, and care was provided. CNA K stated she defined elopement as when a resident was not in the facility. CNA K stated she would notify a nurse if a resident was missing. CNA K stated CNAs monitored residents' wander guard devices and management installed the wander guard alarms. CNA K stated she knew the importance of checking residents' wander guard devices and said, You don't want anything to happen to them. Some people have dementia. They could get hurt out there. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/22/25 at 1:45 p.m., CNA D stated she last saw Resident #1 in his room on 03/15/25 around 3:00 p.m. CNA D stated she was the only CNA working on Resident #1's hall on 03/15/25. CNA D stated the RN Supervisor notified her on 03/16/25 that Resident #1 was missing. CNA D stated she checked on residents every two hours. CNA D stated she knew the importance of checking on residents and said, Because residents who were ADL dependent were bed bound and needed to be repositioned and some residents were incontinent and needed to be changed and some residents had wander guard so to make sure they were in the facility. CNA D stated she defined elopement as a resident who escaped from the facility and wandered into the facility, and no one was aware of it. CNA D stated she would search for the resident and notify the nurse or another supervisor if a resident was missing. CNA D stated she did not know who was responsible for checking residents' wander guard devices and ensuring they were functional and in place. CNA D stated she knew the importance of checking residents' wander guard devices and said, Residents could leave the facility and get harmed easily. If a resident had Alzheimer's disease, they could slip out of the wander guard and leave the facility and wander out into street and no one would know. During an interview on 03/22/25 at 2:05 p.m., the RN Supervisor stated LVN A notified her on 03/15/25 around 10:00 p.m. that Resident #1 was not in his room and missing. The RN Supervisor searched inside and outside the facility, did a head count, and could not find Resident #1. The RN Supervisor stated LVN A notified the police, and she notified the ADM, the DON, and the Pharmacy Coordinator, who told her that she noticed Resident #1's itinerary and suspected Resident #1 left sometime during the day. The RN Supervisor stated CNA L told her that he noticed Resident #1's lunch tray was untouched around 5:30 p.m.-6:00 p.m. and told CNA D, who told him to replace Resident #1's lunch tray with a dinner tray. The RN Supervisor stated she observed Resident #1's dinner tray in Resident #1's room and found his wander guard device in his drawer. The RN Supervisor stated the Memory Care Director and LVN B found Resident #1 at a hotel on 03/16/25. The RN Supervisor stated she defined elopement as when a person wandered off from the facility without a caregiver being aware of him or her leaving the facility. The RN Supervisor stated CNAs and nurses checked on residents every two hours or more frequently on residents who were an elopement risk and had a history of wandering. The RN Supervisor stated she knew the importance of checking on residents and said, To be there to prevent a fall. Residents could fall and be on the floor for a while. The RN Supervisor stated charge nurses were responsible for checking residents' wander guards to ensure they were functioning and in place. The RN Supervisor stated she knew the importance of checking residents' wander guard devices and said, Sometimes wander guards could be loose or not working and sometimes residents could take them off like what happened that night . Residents could elope from the facility and end up somewhere. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/22/25 at 2:35 p.m., LVN A stated she defined elopement as when a resident got out of the building, expressed desire or a need to leave the facility, and not wanting to come back to the facility or be at the facility. LVN A stated she would ask a CNA, look for the resident, and notify the RN Supervisor if a resident was missing. LVN A stated CNA E notified her on 03/15/25 between 9:00 p.m. and 9:30 p.m. that she did not observe Resident #1 in his room since the beginning of their shift, which was from 6:00 p.m. through 6:00 a.m. LVN A stated she observed Resident #1 walking from his room towards what she believed was the facility library around 6:15 p.m. and 6:20 p.m. and did not observe him after that observation because she was conducting medication pass for 48 other residents. LVN A stated she told CNA E to search for Resident #1 in the facility and around the facility's perimeter. LVN A stated she found Resident #1's wander guard device in his drawer. LVN A stated nurses checked residents' wander guard devices every shift to ensure functionality and they were in place. LVN A stated she checked Resident #1's wander guard device at the beginning of her shift on 03/15/25. LVN A stated she observed the exit door at the end of Resident #1's hall did not have an outside wander guard alarm system panel on it during her search for Resident #1. LVN A stated the MS was responsible for checking the wander guard alarm system panel and did not know how often the MS completed that task. LVN A stated she found Resident #1's itinerary, called the hotel, and the hotel staff told her that he was not there. LVN A stated the Memory Care Director called the hotel again and found out Resident #1 was at the hotel on 03/16/25. During an interview on 03/22/25 at 3:09 p.m., CNA E stated CNAs and nurses checked on residents every two hours. CNA E stated she knew the importance of checking on residents and said, Because residents could wander around and get lost and so residents are clean and well-positioned. CNA E stated she defined elopement as when a resident wanders without a trace. CNA E stated she did not observe Resident #1 when she started her shift on 03/15/25 around 6:10 p.m. and 6:15 p.m. CNA E stated she thought she observed Resident #1 underneath his bed sheet in his bed. CNA E stated she noticed Resident #1's dinner tray was untouched and realized Resident #1 was not in his bed. CNA E stated she notified LVN A around 8:00 p.m. CNA E stated her and LVN A searched in the facility and around the facility's premises to look for Resident #1 and notified the RN Supervisor and the police. CNA E stated she observed Resident #1's wander guard device was in his drawer. Resident #1 had a phone on his bed in which he made calls to a cab company on 03/15/25 around 12:13 p.m. Resident #1 had an itinerary listing hotel information and notified LVN A. CNA E stated everyone who cared for the resident was responsible for checking wander guard devices to ensure functionality and they were in place. CNA E stated she knew the importance of checking residents' wander guard devices and said, For resident safety. Residents could leave the building, and no one would know because the alarm would not turn on. During an interview on 03/22/25 at 3:32 p.m., CNA C stated she defined elopement as a resident not being on the premises or in the facility. CNA C stated she would notify the nurse if she could not locate a resident. CNA C stated she last observed Resident #1 walking up the hall towards the nursing station on 03/15/25 around 4:00 p.m. CNA C stated nurses were responsible for checking residents' wander guard devices. CNA C stated she knew the importance of checking residents' wander guard devices and said, Residents could go out the door and get away if a resident's wander guard was not checked. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/22/25 at 3:46 p.m., CNA L stated he defined elopement as when a resident left the facility. CNA L stated he would notify a nurse if a resident was missing. CNA L stated he did not observe Resident #1 in his room during his shift on 03/15/25 from 2:00 p.m. through 10:00 p.m. CNA L stated on 03/15/25 around 5:15 p.m., he was passing out dinner trays and observed Resident #1 was not in his room and his lunch tray was still in his room. CNA L stated he notified an unknown name CNA (CNA D) that he did not observe Resident #1 in his room, observed Resident #1's lunch tray was in his room on his bedside table, and that Resident #1 did not eat his lunch. CNA L stated the CNA (CNA D) told him to take Resident #1's lunch tray and replace it with Resident #1's dinner tray. CNA L stated he did not notify a nurse because he did not know the facility's system because it was his third day of training on 03/15/25. During an interview on 03/22/25 at 4:20 p.m., CNA M stated she defined elopement as a resident who ran away from the facility. CNA M stated she would notify the nurse and the ADM if a resident was missing. CNA M stated CNAs and nurses checked on residents every two hours. CNA O stated she knew the importance of checking on residents and said, To make sure they received care and not trying to leave or on the side of their bed. CNA O stated anyone can check the residents' wander guard devices. CNA O stated she knew the importance of checking residents' wander guard devices and said, Resident could walk out the door and no one would know or be alerted. During an interview on 03/22/25 at 4:33 p.m., LVN G stated CNAs and nurses checked on residents every two hours. LVN G stated she knew the importance of checking on residents and said, To ensure safety and to make sure residents were at the facility. Residents could fall and elope. LVN G stated she defined elopement as a resident who left the facility and did not have the capacity to leave on their own. LVN G stated she knew to notify

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47065 Based on interviews and record review, the facility failed to maintain medical records on each resident that were complete, accurately documented, readily accessible, and systematically organized for 1 (Resident #1) of 12 residents reviewed for elopement. The facility failed to ensure staff's statements were accurately documented when they last observed and checked on Resident #1 before he eloped on 03/15/25. This failure could place residents at risk of not being checked on, eloping, falls, and changes in condition. Findings included: Review of Resident #1's Admission Record, dated 03/21/25, reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, unspecified dementia, depression, and unsteadiness on feet. Resident #1 had an MPOA and FPOA, which were his responsible parties. Review of Resident #1's Admission and Modified MDS Assessments, dated 12/25/24, reflected he had a BIMS score of 12, which indicated he had moderate cognitive impairment. Resident #1 used a wander/elopement alarm daily. Resident #1 required supervision with toileting, bathing, dressing, and transferring, set-up assistance with personal and oral hygiene, and was independent with eating and repositioning. Review of Resident #1's BIMS Evaluation, dated 03/16/25 at 1:46 p.m. by SW, reflected he had a BIMS of 9, which indicated his cognitive status declined since his admission. Review of Resident #1's Admission Assessment, dated 03/21/25, reflected he was a high risk for elopement and had on one or more occasions attempt to exit or had exited the facility. Review of Resident #1's Care Plan, dated 01/01/25, reflected he was exit-seeking and at risk for elopement and/or wandering with unsafe boundaries related to his dementia. Resident #1 was also at risk for falls related to his unsteady gait, poor balance, history of falls, osteoarthritis, and dementia. Review of Resident #1's Progress Notes reflected there were no notes from 02/21/25 through 03/15/25. The progress notes also reflected: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A note by LVN A on 03/16/25 at 6:01 a.m., This nurse was notified by CNA's at approx. 2130 (9:30 p.m.) that resident had not been seen since the beginning of the shift. We began searching his regular spots, like the library and dining room. When we couldn't locate him, RN supervisor was informed and she notified DON and administrator. Family was notified and Police and PD were also informed and responded to the incident. Every hall was instructed to check every room, bathroom, closet and office. The perimeter of the building was searched and Police searched the entire property by their patrol vehicles. DON and administrator were informed and administrator arrived to the facility to aid in the investigation. PD was informed and also arrived on scene to obtain more information about resident's appearance and other pertinent information. Family was informed and kept updated throughout the shift. -A note by the DON on 03/16/25 at 8:26 a.m., Notified by CNAs on duty that resident was not located in room upon rounds. Staff immediately initiated room search which then extended to entire community and campus without identifying resident's location. Said nurse immediately called Administrator, Police and PD to inform of possible missing person. PD onsite and additional details were provided. Family reported that resident has previously done this before and to notify them if resident's whereabouts are identified. Resident confirmed that he left the community yesterday evening with the intention of not returning. Resident is A&O x 4 and verbalized his plans of moving from the area to Oklahoma where he has friends. Resident was asked why he failed to alert the staff of his intentions and resident replied that he chose not to alert staff because he thought that the staff would not allow him to leave the facility. Resident reports that he is not happy with his family and does not want his family making his decisions. Resident has communicated that he is capable of making his own decisions and intends on doing so. Resident is in a local hotel room and reports that his plan continues to be to go to a friend's home and ultimately plans to move to Oklahoma. He stated that may consider a community in Oklahoma or wants his own apartment. He also reported that he is going to store tomorrow to get a phone, but for now he will remain at his hotel. Resident was informed that his PCP has provided orders that he is discharged from community AMA and that his medications will be released to him and that a nurse will review the medications with him as recommended and that Home Health will be referred if he is agreeable. Resident was informed that out of an abundance of caution community will refer to APS for wellness checks as well as possible assistance that he may need for relocating since resident is not agreeable to remain in the facility. Resident was informed that any additional belongings he may have in the community will also be brought to him at the hotel along with his medications and that in good faith the community is going to have a nurse review his medications with him to ensure he is able to properly administer and that we strongly recommend that he allow home health services. Despite education and resident has been discharged AMA at his request. Community will adhere to MD's recommendations for home health referral and out of an abundance of caution SW will notify APS for a wellness check and any additional support that resident may need. -A Late Entry note by the SW on 03/16/25 10:00 a.m., SW was notified that resident expressed a desire to no longer reside at facility. SW was asked to bring the AMA waiver to resident's location. The waiver was signed by resident, with a nurse serving as the witness. SW conducted a Brief Interview for Mental Status exam with resident, scoring 9. Additionally, SW provided information regarding a nursing home in Oklahoma, which resident expressed interest in. Upon returning to facility, SW immediately called APS to report resident leaving AMA. Review of Resident #1's Hotel Registration, printed on 03/15/25 at 2:14 p.m., reflected Resident #1 arrived at the hotel on 03/15/25 and signed his checked in registration in-person. (continued on next page)

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	675857	A. Building B. Wing	03/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
William R Courtney Texas State Veterans Home	1424 Martin Luther King Jr LN Temple, TX 76504

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's MAR/TAR , dated 03/21/25, reflected CNA C documented administering Resident #1's order of 1 drop of Carboxymethylcellulose Sod PF Ophthalmic Solution 0.5 % in both Resident #1's eyes on 03/15/25 at 11:00 a.m. and 4:00 p.m. and the DON documented he was out of the community at 9:00 p.m. Review of Resident #1's Pain Level Summary, dated 03/21/25, reflected staff conducted and documented a numerical pain assessment on Resident #1 in which they indicated he had 0/10 pain on 03/15/25 at 4:48 p.m. Review of Resident #1's POC, dated 03/21/25, reflected CNA D documented Resident #1 ate 76-100% of his meal on 03/15/25 at 1:22 p.m. CNA E documented and signed that she set up Resident #1's meal and supervised Resident #1 eating on 03/15/25 at 9:01 p.m. Review of the facility's Provider Investigation Report reflected the RN Supervisor notified the facility on 03/16/25 that on 03/16/25 at 12:30 a.m., Resident #1 was not present in his room. There were no witnesses. Investigation Summary reflected, At approximately 9:45 p.m., CNAs reported to their charge nurse that they last recalled seeing Resident #1 on 03/15/25 around 6:30 p.m. The charge nurse promptly informed the RN Supervisor, who prompted the team to initiate an initial search. The facility conducted a search of the entire community and immediate area outside the community and could not locate Resident #1. On 03/16/25 at approximately 12:30 a.m., the RN Supervisor notified the ADM, DON, and police. During this process, the RN Supervisor discovered an itinerary in the copy room containing various pertinent details, including information regarding a train company, cab company, hotel, and bank. This information was communicated to the ADM and responding police officer upon their arrival on-site. The search efforts were then expanded within the community by reaching out to the contacts and businesses listed on the itinerary. The ADM first contacted the hotel at approximately 2:00 a.m., only to be informed that Resident #1 was not present there. However, later that morning, the memory care director contacted the hotel again and was informed that Resident #1 was indeed at the hotel. In response, the memory care director, accompanied by another team member and a social worker, proceeded to the hotel to retrieve Resident #1. An assessment was conducted, and attempts were made to persuade Resident #1 to return to the community; however, Resident #1 declined. Resident #1 who has a BIMS of 12 and when assessed by the charge nurse on site shared, he is alert and oriented x4, explained that he had intentionally departed from the community without signing out or notifying his nurse, as he believed the nurse would not support his desire to visit a friend. He expressed plans to continue to a friend's home in Oklahoma, where he preferred to be. Resident #1 was subsequently informed that should he choose not to return, he would need to sign out of the community AMA, which he proceeded to do. One of the team members then returned to the community to collect all of his medications and APS was notified. Additionally, his family was informed that he had been located and was safe. The following morning, the community dispatched a charge nurse back to Resident #1's hotel room to conduct a health and welfare check, ensuring that he remained safe, alert, and oriented. Upon this visit, it was confirmed that he was indeed safe, alert, and oriented, and his family had arrived at the hotel. The facility's investigation findings were unfounded. Staff statements reflected CNA C stated she observed Resident #1 on 03/15/25 in the early afternoon, CNA D stated she observed Resident #1 on 03/15/25 around 3:00 p.m., CNA F stated she observed Resident #1 lying in his bed on 03/15/25 around 5:45 p.m., CNA E stated she observed Resident #1 lying in his bed on 03/15/25 around 6:00 p.m., LVN A stated she observed Resident #1 lying in his bed on 03/15/25 at approximately 6:20 p.m., the RN Supervisor stated she was notified by LVN A that Resident #1 was missing at approximately 10:00 p.m., and the Memory Care Director stated she called and found Resident #1 at a hotel on unknown date. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/21/25 at 11:40 a.m., the ADM stated Resident #1 discharged from the facility and could not recall the discharge date . During an interview on 03/21/25 at 11:49 a.m., Resident #1's FAM stated LVN G called and notified them on 03/15/25 at 10:30 p.m. that the facility staff were unable to locate Resident #1 and were searching for him. The FAM stated LVN G called and notified them on 03/16/25 at 12:00 a.m. that Resident #1 was last observed lying in his bed in his room on 03/15/25 at 6:30 p.m. The FAM stated the ADM called and notified them on 03/16/25 at 12:46 p.m. Resident #1 was found at a hotel. The FAM stated they believed the facility staff were lying about last observing Resident #1 on 03/15/25 at 6:30 p.m. because the hotel staff told them that Resident #1 checked into the hotel on 03/15/25 at 2:13 p.m. The surveyor emailed the ADM a list of records, including requesting to review the facility's in-services from 03/01/25 through 03/21/25, on 03/21/25 at 12:20 p.m. During an interview on 03/21/25 at 2:16 p.m., Resident #1 stated staff last checked on him on 03/15/25 around 6:00 a.m. when they checked his blood sugar. Resident #1 stated he ate breakfast in his room on 03/15/25 around 7:00 a.m. Resident #1 stated he left the facility around 11:00 a.m. and did not return to the facility. Resident #1 stated he walked for two hours to a store (approximately 2.8 miles from the facility), got a ride at some point to the store, got another ride to the hotel, and arrived at the hotel (approximately 10 miles from the store) around 3:00 p.m. and 4:00 p.m. Resident #1 stated the facility staff found him at the hotel on 03/16/25 around 11:00 a.m. During an interview on 03/22/25 at 10:14 a.m., LVN H stated she documented care provided to a resident in residents' progress notes and medications administered to a resident in the residents' MAR. LVN H stated the CNAs documented ADL care provided to a resident in the residents' POC. LVN H stated she knew the importance of accurately documenting care and said, For everyone's knowledge, so there was a reference point and so everyone on the team was involved. Residents could go missing and be lost if there was incorrect documentation. During an interview on 03/22/25 at 10:31 a.m., CNA I stated she documented ADL care provided to a resident in the residents' POC as soon as possible, when she can and in between rounds. CNA I stated she knew the importance of accurately documenting ADL care in the residents' POC and said, Just in case if a fall occurred, a resident felt bad or needed to be changed, to make sure everything was okay with resident and to catch everything quickly. We are all held accountable for documentation. Residents could be missing in action or not be at the facility. During an interview on 03/22/25 at 1:45 p.m., CNA D stated she last observed Resident #1 in his room on 03/15/25 around 3:00 p.m. when he refused his shower that she offered. CNA D stated she was the only CNA working on Resident #1's hall and another hall on 03/15/25. CNA D stated a CNA Trainee (CNA L) was working in the shower room on 03/15/25 around 4:00 p.m. and was working with her on Resident #1's hall. CNA D stated she documented ADL care provided to a resident in the residents' POC after ADL care was performed, refused or before 2:00 p.m. per the facility policy. CNA D stated she knew the importance of accurately and timely documenting ADL care in the residents' POC and said, If you did not document, then it did not happen. To make sure you did not forget anything and make sure the time of the completed task is accurate. Residents could slip out the facility or not receive the ADL care . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/22/25 at 2:05 p.m., the RN Supervisor stated LVN A notified her on 03/15/25 around 10:00 p.m. that Resident #1 was not in his room and missing. The RN Supervisor stated CNA L told her that he noticed Resident #1's lunch tray was untouched around 5:30 p.m. and 6:00 p.m., told CNA D, and CNA told him to replace the lunch tray with a dinner tray. The RN Supervisor stated she documented medications administered and treatments given to a resident in the residents' progress notes . During an interview on 03/22/25 at 2:35 p.m., LVN A stated CNA E notified her on 03/15/25 around 9:00 p.m. and 9:30 p.m. that she had not observed Resident #1 in his room since the beginning of their 6:00 p.m. through 6:00 a.m. shift. LVN A stated she last observed Resident #1 walking from his room towards what she assumed to be the facility's library on 03/15/25 around 6:15 p.m. and 6:20 p.m. LVN A stated she did not observe Resident #1 after the previously mentioned observation of him because she was busy conducting medication pass for 48 other residents. LVN A stated she documented medications administered to a resident in the residents' MAR. LVN A stated she knew the importance of accurately documenting medications administered to residents in the residents' MAR and said, Because to know if resident had a habit of refusing medication. Residents could start having side effects or overdose. LVN A stated she found Resident #1's itinerary that illustrated hotel information, she called the hotel on 03/15/25, and was told he was not there. LVN A stated she was unsure if she documented her call to the hotel in a progress note . During an interview on 03/22/25 at 3:09 p.m., CNA E stated she did not observe Resident #1 during her 6:00 p.m. through 6:00 a.m. shift. CNA E stated she thought she observed Resident #1 underneath his bed sheet in bed. CNA E stated around 8:00 p.m., she noticed Resident #1's dinner tray was untouched, observed and realized Resident #1 was not in his bed, and notified LVN A. CNA E stated during her search for Resident #1, she observed Resident #1 had a phone on his bed that had calls made to the yellow cab on 03/15/25 around 12:13 p.m. and notified LVN A and found Resident #1 had an itinerary that included hotel information that she started making calls to. CNA E stated she documented ADL care provided to a resident in the residents' POC after each round. CNA E stated she knew the importance of accurately and timely documenting ADL care in residents' POC and said, So nurses could give attention to a resident and so changes in condition were found. Residents could have something bad happen to them if ADL care was not accurately and timely documented in POC . During an interview on 03/22/25 at 3:32 p.m., CNA C stated she also worked as an MA. CNA C stated she last observed Resident #1 walking up the hall towards the nursing station on 03/15/25 around 4:00 p.m. CNA C stated she documented medications administered to a resident in the residents' MAR. CNA C stated she knew the importance of accurately documenting medications administered in residents' MAR and said, To make sure the resident received medications on time, resident was visibly seen and taken the medication and for the safety of the resident. Residents could die and anything could happen to them if the MAR was falsified. During an interview on 03/22/25 at 3:46 p.m., CNA L stated he was passing out dinner trays when he observed Resident #1 was not in his room and Resident #1's lunch tray was in his room on 03/15/25 around 5:15 p.m. CNA L stated he notified an unknown CNA (CNA D) he did not observe Resident #1, and observed Resident #1's lunch tray was untouched and still in his room on his bedside table. CNA L stated the unknown CNA (CNA D) told him to take Resident #1's lunch tray and replace it with Resident #1's dinner tray. CNA L stated he did not notify a nurse because he did not know the facility's system because it was his third day of training orientation. CNA L stated he did not observe Resident #1 in his room during his 2:00 p.m. through 10:00 p.m. shift on 03/15/25 . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/22/25 at 7:36 p.m., the Pharmacy Coordinator stated she last observed Resident #1 lying in his bed in his room before dinner on 03/15/25 around 4:40 p.m . During an interview on 03/22/25 at 7:57 p.m., the ADM stated the RN Supervisor notified him on 03/16/25 around 12:10 a.m. and 12:15 a.m. that the CNAs last observed Resident #1 on 03/15/25 around 6:30 p.m. The ADM stated the RN Supervisor also told him the CNAs observed Resident #1's lunch tray was still in his room when conducting a check at 9:00 p.m. The ADM stated he expected the CNAs to document ADL care provided to residents in residents' POC before leaving their shift and nurses to document care provided to residents before leaving their shift. The ADM stated he knew the importance of accurately and timely documenting and said, If we don't document accurately and timely, we could have a negative outcome. During an interview on 03/22/25 at 8:34 p.m., the DON stated the ADM notified him on 03/15/25 around 11:00 p.m. that Resident #1 was missing. The DON stated he expected the nurses to enter medication administrations in residents' MAR within one hour of administering the medication to the resident. The DON stated he expected CNAs to document ADL care in residents' POC within one hour of the ADL care provided to the resident. The DON stated when he reviewed Resident #1's MAR after Resident #1's incident, he found the timeliness and accuracy of documentation was off and in-serviced the staff on MAR documentation. The DON stated he knew the importance of timely and accurately documenting and said, Because it could cause a discrepancy and delay. The ADM did not provide the state surveyor with the facility's in-services from 03/01/25 through 03/21/25. Review of the facility's Medication Administration policy, revised January 2023, reflected: Responsible Disciplines: Licensed Nurses, C.M.A.'s .10. Record the results of medications administered as necessary. Documentation: Initial the electronic administration record after the medication is administered to the resident.