STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675985	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Midland	2000 N Main Midland, TX 79705

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221 Based on interview and record review the facility failed to develop and implement a comprehensive person -centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a residents medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 2 residents (Resident #1) reviewed for supervision related care plans. 1. The facility failed to ensure a care plan was updated for Resident #1's elopements . These failures could place residents at risk for not receiving necessary care and services or having psychosocial care needs identified. Findings include: Review of Resident #1's Admission Record, dated 4/29/25, revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of dementia with behavioral disturbance, brief psychotic disorder (had an episode of seeing things that were there or believing things that were completely irrational). Review of Resident #1 quarterly MDS Assessment prior to the incident, dated 2/24/25, revealed: He had a mental status of 6 of 15 (indicating severe cognitive status) There were no behaviors documented. He had no range of motion impairments. He could walk 150 feet with partial assistance. He was on an antidepressant. Review of Resident #1's care plan revealed: Initiated 4/13/23 Focus: Resident is an elopement risk/wanderer and is in secured unit being at risk for possible injury related to impaired safety awareness and diagnosis of dementia. (continued on next page)

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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Goal: Resident's safety will be maintained throughout the review date Interventions: Distract resident from wandering by offering pleasant diversions, structured activities, televisions, or books. Provide structured activities: walking inside and outside, reorientation strategies, including signs, pictures, and memory boxes. Initiated 4/26/23: Focus: Resident resides in secure unit as is at risk for injury from wandering in an unsafe environment related to diagnosis of dementia as evidenced by impaired safety awareness. Resident is at risk for injury from others while residing in secure unit due to altered cognition. Goal: Dignity will be maintained, and resident will wander about unit without the occurrence of any occurrence of any injury over the next quarter. Interventions: Call by name when giving care, involve in care as much as possible. Resident #1's Elopement Assessment, dated 10/8/24 scored an 11 making him a high risk for elopement. There was no Incident/Accident report for the 11/19/24 elopement in the electronic record. Interview on 5/1/30 at 10:06 a.m. the Administrator stated the MDS coordinator was still doing care plans ultimately. She stated Resident #1 had a history of elopements. She said she was not aware the MDS Coordinator did not make a care plan for the 2023 elopement. The Administrator said they did chart audits once a month. The DON who was present said she did care plan updates often and anything and everything could be done better. The DON said Resident #1 had a care plan for wandering on being on the unit but no care plan for the 2023 elopement. Interview on 5/1/25 at 10:29 a.m. the Regional RN Consultant stated she only checked care plans during the facility's mock survey. She stated the regional staff were supposed to check the care plans after an incident occurred. The Regional RN admitted she did not because she usually looked to see if there was an intervention put in place after the incident. Interview on 5/1/25 at 11:20 a.m. the MDS Coordinator stated everything that the facility needed to do to take care of the resident needed to be care planned. The MDS Coordinator said he did care plans with the MDS Assessments and when incidents happen. The MDS Coordinator stated he did not know he needed to do a care plan with the 2023 elopement and there was noot an incident-accident report completed for the 11/2024 elopement. The MDS Coordinator agreed the elopement was discussed in morning meeting after it happened, he was aware it happened, but he did not know a care plan needed to be done. The MDS Coordinator stated the doctor did not make new orders, that the in-services and door checks covered them. The MDS Coordinator stated, it is what it is, I thought the at-risk care plan - it was covered. Review of the facility's policy and procedure on Comprehensive Care Plan, last revised 4/25/2021 revealed: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Every resident will have an individualized interdisciplinary plan of care in place. The Care Plan in revised ever quarter, significant change of condition, Annual or as the resident condition changes on an individual basis. The Care Plan process is an ongoing review process. Procedure. The Interdisciplinary Team will review the healthcare practitioner's notes and orders and implement a Comprehensive Care Plan to meet the residents' immediate care needs including but not limited to: Psychosocial Mood State/Adjustment to Placement Any updated information based on the details of the comprehensive care plan, as necessary.

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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** 26221 Based on observations, interviews and record review the facility failed to ensure the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 2 residents (Resident #1) reviewed for accidents and supervision, in that: Resident #1 eloped on 11/19/24 out of the facility and across a 35-mph street and was found at a school 0.8 miles away 2 hours later by police. An IJ was identified on 5/2/25. The IJ template was provided to the facility on [DATE] at 12:44 PM. While the IJ was removed on 5/2/2025 at 8:35 PM. The facility remained out of compliance at a scope of isolated and severity level of no actual harm with a potential for more than minimal harm that is an immediate jeopardy due to facility's need to evaluate the plan of removal. This failure could place residents at risk of severe injury or even death. The Findings were: Review of Resident #1's Admission Record, dated 4/29/25, revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of dementia with behavioral disturbance, brief psychotic disorder (had an episode of seeing things that were there or believing things that were completely irrational). Review of Resident #1 quarterly MDS Assessment prior to the incident, dated 2/24/25, revealed: He had a mental status of 6 of 15 (indicating severe cognitive status) There were no behaviors documented. He had no range of motion impairments. He could walk 150 feet with partial assistance. He was on an antidepressant. Review of Resident #1's care plan revealed: Initiated 4/13/23 Focus: Resident is an elopement risk/wanderer and is in secured unit being at risk for possible injury related to impaired safety awareness and diagnosis of dementia. Goal: Resident's safety will be maintained throughout the review date Interventions: Distract resident from wandering by offering pleasant diversions, structured activities, televisions, or books. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide structured activities: walking inside and outside, reorientation strategies, including signs, pictures, and memory boxes. Initiated 4/26/23: Focus: Resident resides in secure unit as is at risk for injury from wandering in an unsafe environment related to diagnosis of dementia as evidenced by impaired safety awareness. Resident is at risk for injury from others while residing in secure unit due to altered cognition. Goal: Dignity will be maintained, and resident will wander about unit without the occurrence of any occurrence of any injury over the next quarter. Interventions: Call by name when giving care, involve in care as much as possible. Resident #1's Elopement Assessment, dated 10/8/24 scored an 11 making him a high risk for elopement. There was no Incident/Accident report for the 11/19/24 elopement in the electronic record. Review of Resident #19's Nurse's Notes revealed no nurse's notes for 11/19/24. The next nurse's note was dated 11/21/24 and read: Nurse Practitioner rounded on resident today, no new orders noted/ After occurrence this week with resident escaping from facility lockdown unit. Review of the facility's investigation revealed on 11/19/24: Staff reported Resident #1 was missing at 6:00 p.m. RN A ordered a search of the facility and notified the Administrator and DON. Administrator and DON came to the facility. They notified the police. The Administrator drove through the neighborhood while the DON stayed at the facility. The facility completed the head count. Police found Resident #1 west of the facility 0.8 miles away at 8:45 p.m. Facility notified physician. Facility completed skin assessment with no injuries found to the resident. Facility changed the number to the doors to the secured units. Management began an Inservice to the staff about not allowing residents to follow people out the door. Review of the facility's investigation dated 11/25/24 revealed resident went out of secured unit behind a girl is what he is saying. Verification on Accuweather.com revealed the temperature was between 39- and 68-degrees Fahrenheit. Sunset was 5:45 p.m. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 4/28/25 at 10:45 a.m. the Administrator stated Resident #1 made it to the school on {x} street. The also present DON stated the {x} school was about 3/4 a mile away. The Administrator stated that weekend the facility had a plumbing problem, and the facility was replacing plumbing, and Resident #1 followed the contract worker out the door. The DON stated Resident #1 crossed their street (30 mph) and walked down the other street (35 mph). The DON stated the police officer found Resident #1 at the school and the only thing wrong with him was his brief was full of poo. The DON stated the staff should have seen the elopement attempt coming and all the staff knew to keep the door shut. The DON said they told the workers in Spanish but did not know how much they understood. The DON said it did not matter the staff all knew. The DON said they did not have a staff member designated to watch the door because she assumed the staff would do their job. The DON said this time Resident #1 got out of the building by following someone out the door of the secured unit and then left out the front door. The DON said Resident #1 felt like he did not belong at the facility. Interview on 4/29/25 at 8:55 a.m the DON stated the facility did QA the situation and their added solution was there would be a dedicated person at the door while there was construction going on. Observation on 4/29/25 at 12:44 p.m. of the neighborhood revealed the road the facility was on was 30 mph . The road the resident went down was a four-lane divided road with a draw (long drainage ditch) between the two lanes, and the speed limit was 35mph. There were four stop signs between where the resident was found and the facility. There was a sidewalk. Interview on 4/29/25 at 11:45 a.m. the DON stated there was a lack of documentation on Resident #1 because her nurses did not like to document anything. The DON reviewed Resident #1's documentation and stated all she could find was the 11/21/24 nurses note documenting the NP visit. Interview on 4/29/25 at 1:00 p.m. the DON stated there was no incident-accident report for Resident #1's elopement on 11/19/24. The DON said it was missed and did not have an answer for why. The DON said the facility did do a skin check for Resident #1 when he returned and every 15-minute checks, but those would not be in his clinical record. The DON stated the physician was notified. The DON said Resident #1 was his own Responsible Party so there was no Responsible Party to notify. The DON stated at the time the facility was working off electronic 24-hour reports and new nurses were not putting in everything they needed to. The Administrator joined the conversation and admitted the lack of documentation was a staffing failure and Resident #1 now lived on the smaller of the two secured units where it would be harder for him to slip through the cracks. Interview on 4/29/25 at 5:47 p.m. the Administrator admitted she did not take statements from the night staff about what happened with Resident #1's elopement. She said she was just tired, relieved to have him back, and forgot. The Administrator said her investigation showed it happened around 5 p.m. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 4/29/25 at 6:27 p.m. RN A stated she was a charge nurse the night Resident #1 got out, but she was not Resident #1's charge nurse. RN A stated she was getting shift change information from LVN B and MA C when a CNA came off the unit saying she could not find Resident #1. RN A said she could not remember which CNA it was. RN A said she directed the CNA to go check the rooms on the units. RN A said it was shift change so she and LVN D checked the outside of the building. RN A stated they came back in and told everyone what to do. RN A said she called the DON. RN A stated she directed everyone to do a room-to-room search to include checking bathrooms, and closets. RN A said she and LVN D did a head count and everyone else was accounted for. RN A stated the DON and Administrator came at that point. RN A stated she told the DON what she (RN A) told the staff to do up to that point. RN A said the DON and Administrator started the corporate protocols at that point, the DON called the police while the Administrator went to go search for the resident. RN A stated she did not remember when Resident #1 came back but he was ok. RN A said she did not know how Resident #1 got out the building because she was charge nurse over the other side of the building. RN A said nothing stood out as unusual when she got to the building that day. Interview on 4/30/25 at 9:18 a.m. CNA E said she worked the 6 a.m. - 6 p.m. shift. CNA E stated her memory of Resident #1 getting out of the building was fuzzy. CNA E stated she did not know if that was how Resident #1 got out or not, but she remembers there was a lot of construction going on at the unit that day. CNA E said she did not know Resident #1 had eloped until he was gone. CNA E stated Resident #1 got his breakfast and lunch trays and remembered checking on Resident #1 in his room when she did rounds. CNA E said she never asked Resident #1 how he got out. CNA said there was nothing else unusual about that day. CNA E said after the incident they had an in-service about making sure the door was closed, the door code was changed, and that Resident #1 room was changed. Interview on 4/30/25 at 10:19 a.m. CNA F said he worked 8 a.m. - 8 p.m. and he worked the day Resident #1 got out. CNA F said that day Resident #1 could not stay still. CNA F said there was maintenance going on in the unit so there were carts in and out. CNA F said people had to know to pull the door shut to make sure it closed, or the residents would follow people out. CNA F said since Resident #1 could no longer get through the fence he followed someone out the unit door. CNA F said Resident #1 did not move quickly, but if someone was pulling a cart behind them, Resident #1 would be able to follow. CNA F said he was surprised Resident #1 got 0.8 miles away before he was found since Resident #1 walked with the limp. CNA F said after the elopement they were told to watch the residents more, but CNA F did not know how since residents went outside on the patio as well. CNA F said the staffing pattern was two people on E hall and two people on F hall - which left one aide to do aide work and one person to watch the hallway and the patio to monitor residents. CNA F said he worked 8 a.m. to 8 p.m. to reduce some of the chaos that happened at shift change and worked the men's unit exclusively. CNA F stated since Resident #1 eloped the facility worked on the door magnets, changed the code, moved Resident #1 to another hall, in-serviced staff and told the staff to watch the residents more . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 4/30/25 at 12:23 p.m. LVN B confirmed she was a charge nurse the day Resident #1 got out. LVN B stated she stayed after her shift after the CNA said Resident #1 was missing. LVN B said the aide came out of the unit asking if anyone saw Resident #1 and the staff were unable to find Resident #1. LVN B said she did not know what time that was, but she thought it was between 6 p.m. and 6:15 p.m. LVN B stated the staff checked the other unit the patio was attached to because you never know and then rechecked the hall Resident #1 lived on. LVN B said all staff were alerted to check the whole building. LVN B said it took an extra hour to hour and a half. LVN B said they were unsuccessful, after they checked the outside, she just left. LVN B said the next day she learned they found Resident #1 at a school. LVN B said no one told her how Resident #1 got out . LVN B said that day there were a lot of people in and out of the unit because there was construction going on. LVN B said they did not know if the construction workers left the door open. LVN B said it was unclear how he got out. LVN B said LVN D worked Resident #1's hall during the day. LVN B said she did not remember which night aide told them the resident was gone. Interview on 4/30/25 at 12:32 p.m. LVN D stated she was Resident #1's charge nurse. LVN D said no one reported to her Resident #1 was missing. LVN D stated CNA G's statement that documented she told a nurse Resident #1 was missing was false. LVN D said CNA G no longer worked at the facility. LVN D stated no one told her Resident #1 was gone. LVN D said CNA G may have told MA C. LVN D said she could not remember that day, but she knew he was there because she put her eyes on everyone before dinner, LVN D just could not recall if she saw him. LVN D said they called the Administrator twice that day but did not remember why. LVN D said there was an in-service about missing residents but could not remember anything else. Interview on 4/30/25 at 4:02 p.m. MA C stated he kind of remembered some of the incident of Resident #1's elopement. MA C said they were doing maintenance on Resident #1's side of the men's secured unit. MA C stated there were a lot of people going in and out. MA C said he thought Resident #1 just followed them out. MA C stated he could not remember what time it was. MA C he was not assigned to pass medications down that side of the building. MA C stated no one told him a resident was missing, if they did, he would search room to room and check the entire facility and then check with the Administrator to see what needs to be done. MA C stated he believed Resident#1 was gone a couple of hours. MA C said residents hung out on the patio area and the staff were responsible for keeping up with where the residents were, and it was difficult to keep up with the patio, the day room, and the resident's room plus being an aide. Interview on 5/1/25 at 10:29 a.m. the Regional RN Consultant stated she only checked care plans during the facility's mock survey. She stated the regional staff were supposed to check the care plans after an incident occurred. The Regional RN admitted she did not because she usually looked to see if there was an intervention put in place after the incident. The Regional RN Consultant stated after an Elopement she expected to see if the resident was checked for a UTI, were doors locked and/or alarming, making sure that the residents could not get out and if there was a system failure. The Regional RN stated she remembered the facility reported the incident occurred to the corporate staff, but they were not part of the plan of correction, and they were not part of monitoring the plan of correction. The Regional RN stated usually if the facility had a self-report, she would go over it. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 5/1/25 at 1:00 p.m. Resident #1's physician stated the facility notified him of the elopement and the NP did an as needed visit the next day to verify there were no injuries. The physician reviewed Resident #1's notes and stated the only medication Resident #1 had ordered in the last 3 years was diphenhydramine so Resident #1 was medically stable. The physician stated he had not issues with how the units were being run. Observation on 5/1/25 at 4:22 p.m. revealed two maintenance worker bringing dirt into the patio area on the men's unit to level it out. One male resident was sunning himself on the ground, another resident came out to smoke. There was one of the employee's children intently staring at the open gate. Surveyor asked him if his job was to watch the gate, he shrugged, and continued to stare at the open gate. Interview on 5/2/25 at 10:10 a.m. the DON stated the facility was supposed to be doing head counts every day - that was the responsibility of the ADON who was no longer with the facility. The DON did not know when that stopped or why that stopped. The DON said after Resident #1's elopement the facility also changed the physical keypad to all the doors, changed the codes, secured the furniture to the patio so the furniture could not be moved for residents to climb over the fence, referred Resident #1 out to other facilities. The DON said she thought there were some in-services with maintenance department, but she could not remember - it was not her department, so she was not sure. Interview on 5/2/25 at 10:17 a.m. surveyor attempted to call the previous ADON and left a detailed message requesting a call back. Interview on 5/2/25 at 10:45 a.m. the DON stated, as a general rule Resident #1 wore a beige jacket he would not take off, a t-shirt and jeans. The DON said she did not remember exactly what Resident #1 wore on 11/19/24 except jeans because the officer was so mad about the poop falling out of it. The DON said she was unable to find any of the head count forms the previous ADON was responsible for monitoring. 5/2/25 at 11:54 the DON showed surveyor where the plumbers were working, and one of three rooms was Resident #1's. Review of the facility's investigation dated 11/20/24 revealed: The DON's statement revealed: I received a call that resident was not on the unit. We told the staff to check every room and every bathroom, closet and any place someone could be hiding and myself and the Administrator went down the street to look for him. Several staff came out to look for him and we called the police and spoke to an officer and gave a report of him missing. At about 8:45 p.m. an officer called the facility and said that he had found him and was bringing him back home. Resident arrived in the police car with no injuries to himself and returned to his room. When asked how he got out he said that he followed a girl out. We in-serviced staff on making sure no one is exiting the doors with you and that the doors are shut and locked before leaving. We did in-services on ensuring no on follows you out of the unit. He is back home with no injuries' and safe. We also notified the physician. Resident is his own responsible party. We started a head count and looked around the premises of the building and then started a search and called the police to get them to help us to look for him as well. Making sure no one is following you out of the doors and that they are secure before you walk away. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Statement from Pest Control the Administrator called: Spoke with Pest Control and he said he thought he saw someone matching description out in parking lot around 5 or so. CNA F's statement revealed: He was here. I don't know what happened. CNA E's statement revealed: He was here at breakfast and lunch. Dinner hadn't been served when I left but I saw him. Dated 11/20/24 CNA G's statement revealed: I went to hand out dinner trays and I noticed he wasn't here and I told the nurse. We started checking everywhere. Dated 11/19/24 MA C written by the Administrator revealed: Spoke with MA C who just said Resident #1 was not here and we couldn't find him. He did not know how he could have gotten out. Administrator's statement dated 11/19/24 revealed: was notified about elopement of Resident #1. Called ADON and went and picked her up. Called Regional Director. Everyone was out looking. DON was in building looking everywhere. Called police to get more eyes out. We were driving around from about 6:40 p. m. until about 8:30 p.m. when we were notified he was back at the building. Police officer found him down by school. Asked him how he got out and he said he waited until he saw an opportunity and then walked out when no one was looking. It seems the door did not close after workers leaving the unit and he just followed them out. He said he was going to follow the water until he got somewhere else. Started in-service on making sure doors are closed when exiting and to watch closely when workers like construction or plumbers are on the unit. Review of in- services, dated 11/21/24, revealed the facility trained all departments on watching doors when construction was going on and always checking doors behind you when leaving. Review of the facility's QA minutes dated 12/12/24 revealed 11 staff discussed the incident and determined the fix was if there was ongoing construction all staff needed to know, and they needed to be at the door and contract staff needed to know they could not let anyone out with them. Review of the facility's Policy and Procedure on Elopement, effective 11/1/19 revealed: Policy: To safely and timely redirect patients/residents to a safe environment. A prompt investigation and search will be conducted if a patient/resident is considered missing. Procedure: 1. Once it has been established that a patient/resident is missing, the following staff members are notified immediately: the charge nurse, Administrators, DON, and social service designee, responsible party and the primary care physician. Complete the missing resident profile. Make note of the outside temperature. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675985	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Midland	2000 N Main Midland, TX 79705

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. The DON or designee organizes and institutes an immediate and thorough search of the center and surrounding ground. Conduct a headcount of each unit. Including, but not limited to a search of the area outside the nearest exit to the patient's/resident's room or the exit he/she was last seen, and the entire unit where the patient/resident resides or was last seen, the remainder of the facility, all rooms, closets - including storage facilities' - bathrooms and grounds extending beyond the fence line. Check all offices and any locked door to ensure non were left unlocked. 3. The entire search process of the facility and grounds, from the time the patient/resident is missing should be completed within 30 minutes. 4. IF the search fails to locate the missing patient/resident within 2 hours from the time patient/resident is found to missing, the Administrator and/or designee contacts the appropriate community agencies (Local Law Enforcement) and update the patient's/resident's legal representative. Staff will provide the police with all physical identifying information including but not limited to physical appearance, height, weight, age, sex, and clothing if known. 5. The search is continued. Two staff members search the surrounding streets by car for a two (2) mile radius around the facility. 6. When the patient/resident is located the nurse completes a head-to-toe assessment. The social service designee assesses the patient/resident for emotional distress. The charge nurse reports any findings to the DON. The DON notified the Administrator or designee and notifies the appropriate community agencies, attending physician, and patient's/resident's legal representative. The Director of Clinical Operations, Regional [NAME] President of Operations and DON were notified of an IJ on 5/2/25/ at 12:44 p.m. and was given a copy of the IJ Template and a Plan of Removal (POR) was requested. The Plan of Removal accepted on 5/2/2025 at 4:50 PM and included the following: Door codes changed on 5/02/2025 All residents will have a current Elopement Assessment done by the DON/ADON/Charge nurse to be completed by 5/2/25 Resident have updated Kardex for those identified at high risk for elopement based on updated elopement assessments, by the DON or designee by 5/2/25 Care plan audits completed by Regional [NAME] President of Operations/ Regional Director of Clinical Operations to reflect any changes in elopement status based on new assessments conducted by DON or Regional Director of Clinical Operations. By 5/2/25 In-service initiated on 5/2/25 for all staff on Elopement policy and procedure by DON. All staff will have this in-service prior to the start of their shift and will also be included in the orientation process with any newly hired staff. To be completed by 5/2/25. One to one in-service with DON by Regional [NAME] President of Operations regarding Elopement Policy and interventions to reduce risk of elopement with resident who are at risk or exit seeking 5/2/25 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Licensed nurs3es in-serviced on using the Fire Alarm and Secured Unit Exit Release Activation and will also be included in the orientation process with any newly hired staff. To be completed by 5/2/25. Ad hoc QA meeting held with the Medical Director on 5/2/25 to inform him of the Immediate Jeopardy. Policy on Elopement was reviewed with no changes recommended. Fire alarm and Secured Unit Exit Release Activation Form as well as residents assessed at risk for elopement will be reviewed each month in the facility's QA meeting. Residents who leave the secured unit or facility will be accompanied by a staff member or responsible party until they return to the secured unit. The nurse assigned to the resident will monitor that the resident returned to the secured unit. No changes in assessment of current residents noted from Risk assessment completed on 5/2/25. DON/Administrator will monitor staff knowledge of elopement policy. Verification of 6 residents files showed that elopement assessments were completed on 5/2/25. Surveyors monitored the facility's Plan of Removal and confirmed it was sufficient to remove the IJ through observations, interviews, and record reviews from 5/2/24 at 12:44 through 5/2/25 through 8:35 p.m. Observation on 4:55 p.m. revealed the DON was changing the code to the secured unit and showing it to the staff one on one. Director of Clinical Operations was in- servicing all nursing and aides one on one. The DON was in- serviced one on by the [NAME] President of Clinical Operations on 5/2/25. 5/2/25 Inservice by DON to nurses: Every nurse is responsible for head count at the start of their shift. If a resident is not in the facility, you should first check the sign out sheet. If the resident has signed out. You should account for that next to their name on the printed census for head count. Head count must be done at shift change/or nurse in charge change and with and emergency button pull or incident that leads to secure unit doors or gates coming open. Thes head counts must be turned into the DON under the DON's door. Do not put them in the DON's box. If any resident is not in the facility and not signed out DON and Administrator must be called at once. DON wants the nurses completing the count to sign/initial the halls they verified. DON will take these counts to morning meeting daily also. Inservice by DON on 5/2/25 on Fire Alarm/Secure Unit Emergency Exit Release Activation. Any time the fire alarm is activated or the emergency buttons are pulled on any other incident that releases secure unit doors or gates, the charge nurses are responsible for completing the attached form includes the date and time of the activation, how long or when the facility secure door and gates are resecured and that all residents in secure units are accounted for. This form should be turned into DON's office as well as a phone call to DON to let DON know this occurred. Please call after count has been completed so you can verify that all residents are present. DON will take these counts to morning meeting daily also. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews on 5/2/25 between 5:13 p.m. and 7:06 p.m. Nurses: LVN D, LVN J, LVN M (Day shift) and LVN RN T, LVN W (night shift) said the responsibilities and expectations of nurses to prevent an elopement. They were responsible for monitoring the gate at shift change that was documented in the narcotic book, doing a head count that was to be slipped under the DON's door, what to do if the fire alarm was pulled and what documentation needed to be done, incident-accident reports, and that a resident off the unit was to be signed in/out and be accompanied at all times by staff. The nurses were able to verbalize what to do in case of a possible elopement, who/when to notify and how to search a room. Interviews on 5/2/25 between 5:32 p.m. and 6:40 p.m. day shift: MA K, MA S (8 a.m. - 8 p.m.) were able to state the code on the unit had changed, what to do if a resident was discovered missing including how to do a room-to-room search, and that they were to sign a resident in/out of the unit and stay with them at all times. Interviews on 5/2/25 between 5:36 p.m. and 6:58 p.m. day shift aides CNA I, CNA L, HA N, CNA O, CNA P, HA Q, CNA R, CNA U, HA V (8a - 8 p), were able to say the code on the unit had changed, what to do if a resident was discovered missing including how to do a room-to-room search, and that they were to sign a resident in/out of the unit and stay with them at all times. Interviews on 5/2/25 between 6:48 p.m. and 7:42 p.m. Night shift aides CNA X, CNA Y, CNA Z, were able to state the code on the unit had changed, what to do if a resident was discovered missing including how to do a room-to-room search, and that they were to sign a resident in/out of the unit and stay with them at all times. The MDS Coordinator was provided one on one in-service on care planning. The DON, [NAME] President of Regional Operations, and Regional Director of Clinical Operations were informed that the IJ was lifted as of 5/2/25 at 8:45p.m. but the facility remained out of compliance at isolated at a level of no actual harm with potential for more than minimal harm due to their lack of time to monitor their corrective actions. Observation on 5/5/25 at 8:45 a.m. revealed the Administrator standing in front of the keypad of the door to one of the male secured units as she talked to a resident from pushing on the doors. Observation on 5/6/25 at 8:45 a.m. revealed a CNA leaning against the keypad of the door of the male secured unit as she tried to talk to the same resident from pushing on the door. Review of head counts from 5/1/25 through 5/5/25 found some that were not in the right time. Interview with the DON at 5/6/25 at 9:01 a.m. revealed she called the night shift and told them to do a drill count to make sure they had it right. DON was able to show where the count was completed at shift change. The DON was able to show where there were Emergency Exit Activation Forms also completed by nurses from drills and from residents pulling the alarm. The DON produced where all staff were in-serviced prior to beginning shift on their responsibilities on preventing an elopement.