STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676152	A. Building B. Wing	05/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seven Acres Jewish Senior Care Services, Inc	6200 N Braeswood Blvd Houston, TX 77074

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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** 46678 Based on observation, interview, and record review, the facility failed to ensure the residents environment remained as free of accident hazards as is possible and ensure each resident received adequate supervision for two (Resident #35 and Resident #1) of six residents reviewed for accidents and hazards. 1. The facility failed to ensure Resident #35 was free of accident hazards when CNA A used a mechanical standing lift (a medical device that assists individuals with limited mobility in transitioning from a seated to a standing position) while showering the resident, which resulted in the resident's foot slipping from the lift, falling to her knees, and sustaining compression fractures (a break in a vertebrae and then collapses to) the L1, L3, L4, and L5 vertebrae on 2/11/25. 2. The facility failed to ensure Resident #1 was adequately supervised to prevent her from leaving the facility unsupervised on 03/25/2025. An Immediate Jeopardy was identified on 04/30/25. The Immediate Jeopardy template was provided to the facility on [DATE] at 5:50 pm. While the Immediate Jeopardy was removed on 5/4/25, the facility remained at a level of no actual harm at a scope of isolated that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk for harm, pain, and injury. Findings included: Record review of Resident #35's face sheet, dated 4/29/25, revealed an [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included: wedge compression fracture of unspecified lumbar vertebra, polyneuropathy (the simultaneous malfunction of many peripheral nerves throughout the body), unspecified dementia (a group of thinking and social symptoms that interfere with daily functioning), pain in unspecified lower leg, low back pain, other osteoporosis without current pathological fracture. Record review of Resident #35's comprehensive MDS dated [DATE] indicated she had a BIMS score of 6 which indicated a severe cognitive impairment. (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Further review of the comprehensive MDS indicated she was dependent on staff for toileting, shower/bathe self, lower body dressing, putting on/taking off footwear, personal hygiene, roll left and right, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer. Record review of Resident #35's care plan dated 1/9/25 indicated she was limited in her ability to transfer due to impaired mobility; she was unable to ambulate or stand. Interventions included: assist with transferring using the full body lift (a type of lift used to assist caregivers in lifting and transferring individuals who are unable to move themselves independently) , 2-person assist, keep call light within reach, monitor extremities to avoid injury, notify nurse if any injury occurs, provide 2-person assistance for transferring, and when transferring, resident should be face-to-face with caregiver. Record review of the Physical Therapy Plan of Care dated 2/22/24 indicated Resident #35 was at a level of maximum assist (76-99% assist) with transfers. Further review of Resident #35's care plan dated 1/9/25 indicated she was at risk for falling r/t impaired mobility, decreased muscle strength. Resident #35 uses w/c for mobility with full staff assistance. Fall r/t standing lift 2/11/25. Interventions included: transfer to hospital for evaluation, keep bed in lowest position with brakes locked, keep call light in reach at all times, keep personal items and frequently used items within reach when appropriate. Record review of the incident/accident report for February 2025 indicated on 2/11/25 Resident #35 was lowered to her knees in front of shower chair to ER for eval fx L1. Record review of Resident #35's progress note dated 2/11/25 at 5:21 pm by LVN A reflected the following: Reported by CNA A resident was being showered and CNA A was using stand up lift to transfer back to wheelchair after shower. Resident's foot slipped off the pedal causing the sling to move upward. CNA A loosened sling and she was lowered to her knees in front of shower chair. This is the position this writer observed when called to the shower room at 4:30 pm. No LOC. 3-11 supervisor called to floor at 4:35 pm and 911 was called at 4:39 pm by supervisor. RP called at 4:39 pm. T 97.4, P 56, R 20, B/P 143/67, O2 sat on RA 96%. ROM x4 extremities. No internal or external rotation of the feet or negs noted. NVS WNL. Resident stated, I hurt all over. EMS here at 4:55 pm. Resident in transit via stretcher to hospital at 5:10 pm. Interview with Resident #35 on 4/30/25 at 8:58 am, she said she could not remember the incident that happened in the shower, she could not remember if she was injured. Resident #35 said she remembered going to the hospital but could not remember why she was there. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interview with CNA A on 4/30/25 at 12:32 pm, she said before she gave Resident #35 a shower, she tested the standing lift in the shower room. After testing the standing lift, CNA A said she brought Resident #35 in her wheelchair to the shower room and hooked her up to the standing lift. CNA A said as she was lifting Resident #35 up with the lift, she noticed Resident #35's leg slip off the platform of the lift. CNA A said she called for help and CNA B came over to assist. CNA A and CNA B unhooked Resident #35 from the lift and lowered her to the floor. RN A was notified and came to the shower room to assess Resident #35. CNA A said she could not remember if Resident #35 said anything at that time. CNA A said after RN A assessed Resident #35, she, CNA B and RN A got her off the floor and put her in the wheelchair. CNA A said she was wheeled back to her room and put her in the bed. CNA A said she and CNA B stayed in the room with the resident while RN A stood in the hallway and waited for EMS to arrive. CNA A said EMS showed up within 20 minutes. CNA A said she was suspended for 3 days and was fired. Interview with CNA A on 5/2/25 at 12:30 pm, she said LVN A told her to take Resident #35 to her room and transfer her to the bed. She said at the time of the incident Resident #35 was supposed to be transferred using a standing lift. CNA A said she had seen the Family Member use a standing lift on Resident #35 as well. CNA A said the charge nurse would tell her if a resident was standing lift or Hoyer. CNA A said the risk to the resident when the wrong type of lift was used was an accident can happen. Interview with CNA B on 4/29/25 at 6:08 pm, she said she was in the shower room with her resident when CNA A called for help. CNA B said when she came over to help, she saw Resident #35 on her knees on the platform of the lift and the sling was around her chest area. CNA B said Resident #35 was not alert, but her eyes were open. CNA B said she held Resident #35 from underneath her arms until RN A came. CNA B said she and RN A tried to lift Resident #35 to put her in the wheelchair but were unable to. CNA B said she went back to her resident in the shower room once LVN A showed up. CNA B said she was not aware of any injury to Resident #35. Interview with RN A on 4/30/25 at 7:26 pm, she said she was giving out medication in room [ROOM NUMBER] when she was alerted by CNA C to go to the shower room. RN A said by the time she got to the shower room; she saw Resident #35 kneeling on the floor. RN A said Resident #35 was leaning sideways towards the tub. RN A said she stood in between the shower tub and the resident so Resident #35 was leaning on her lap. RN A said LVN A checked Resident #35's vitals. After Resident #35's vitals were taken, RN A said the resident was transferred to her wheelchair by Hoyer lift. RN A said Resident #35 was taken back to her room and EMS showed up shortly after. RN A said Resident #35 has always used the standing lift. RN A said Resident #35 was now on Hoyer lift since she came back from the hospital. Interview with CNA C on 5/2/25 at 10:53 am, she said she was in the shower room next door when she was called for help. CNA C said she saw Resident #35 on the floor. CNA C got RN A to help Resident #35. CNA C said she, CNA A and LVN A put Resident #35 in her wheelchair. CNA C said once Resident #35 was in her wheelchair, she went back to the shower room next door. CNA C said at the time of the incident, staff were using a standing lift for Resident #35. CNA C said there was an assignment binder located at the nurse's station that shows what type of lift each resident uses. CNA C said she was not sure how often the binder was updated. CNA C said the risk to the resident when the wrong type of lift was used could cause injury to the resident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interview with LVN A on 5/1/25 at 3:20 pm, she said she was at the nurse's station when she was alerted Resident #35 was on the floor. LVN A said when she went to the shower room, she saw Resident #35 on the floor. She said Resident #35 was on her knees in front of the shower tub. LVN A said she assessed Resident #35 while she was on the floor. LVN A said Resident #35 stated I hurt all over. LVN A said CNA A and CNA C assisted Resident #35 off the floor and into her wheelchair using the Hoyer lift. LVN A said CNA A told her that she was alone when she was operating the standing lift. LVN A said the RN Supervisor told the CNA A and CNA C to keep Resident #35 in the shower room. LVN A said she was not sure who took Resident #35 back to her room, she thought it was CNA A and CNA C. She said the RN Supervisor made the phone calls to EMS, family, MD, DON, and Administrator. LVN A said the risk to the resident when the wrong type of lift was used was, they could fall because the resident would not be able to bear weight on their legs. Interview with the Nurse Practitioner on 4/30/25 at 2:23 pm, she said she remembered getting a phone call about the shower incident with Resident #35. The NP said because of the fall, Resident #35 sustained a fracture to the superior end plate of L1 and chronic compression fracture of the L3 to L5 vertebrae. The NP said this type of fracture can happen when a person sits or lands hard on a surface. She said this type of injury could not happen if a person slid down slowly onto the floor. The NP said the risk to the resident when the wrong type of lift is used could be major injury. Interview with the Physical Therapist on 5/1/25 at 11:51 am, he said Resident #35 has been on a Hoyer lift for at least a year. The Physical Therapist said Resident #35 was not a good candidate for the stand-up lift, because she was not able to roll on her own and did not follow directions. He said Resident #35's family requested to have her out of bed daily. He said the risk to a resident when the inappropriate lift is not used was they could fall. Interview with Resident #35's Family Member on 4/29/25 at 4:44 pm, she said LVN A initially told her about the shower incident. The Family Member said CNA A was by herself when she loosened the sling and Resident #35 fell to her knees. The Family Member said none of the staff told her Resident #35 hit her head. The Family Member said CNA B told her the sling was around Resident #35's neck and was choking her. The Family Member said when Resident #35 was hospitalized , Resident #35 had an egg sized hematoma on her forehead, scratches on the side of her face, and her shins were bruised . The Family Member said Resident #35 had an L1 fracture that required a kyphoplasty procedure (a surgical procedure used to treat painful compression fractures of the spine) and her L3, L4, and L5 vertebrae were fused. The Family Member said Resident #35's flexibility and functional ability will never be the same after the accident. The Family Member said before the shower incident she used the standing lift to transfer Resident #35 and requested staff to use the standing lift as well. Interview with the DON on 4/30/25 at 3:11 pm, she said the CNAs were expected to follow the policies and procedures for transfers when using the lifts and listen to the nurses. The DON said Resident #35 was supposed to be on a full body lift and not the standing lift. The DON said Resident #35's Family Member requested to use the standing lift. The DON said they had a meeting with the Family Member around 10/15/24 and gave her the PT evaluation. PT had recommended full body lift for Resident #35. The DON said the risk to the resident when the wrong type of lift was used was injury to the resident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of the Transfer Techniques policy dated 6/13/16 and last reviewed on 2/12/25 under section Mechanical lift using lift equipment read in part . If resident requires lift equipment, nursing staff are to ensure .the correct lift is being used .all residents require 2 person transfer with lift equipment . On 4/30/25 at 5:50 p.m., the Administrator was informed that an Immediate Jeopardy situation was identified due to the above failures. The following Plan of Removal was submitted by the facility and accepted on 5/2/25 at 3:15 p.m.: PLAN OF REMOVAL - Version 6 Name of Facility: Submitted Date: May 2, 2025 F689 Free from Accidents and Incidents The facility failed to use the proper lift on Resident #35 because CNA A used a standing lift, at the request of the family member, instead of following the plan of care which required a Hoyer lift for transfer resulting in an injury to the resident. 1. On February 18, 2025, CNA A was terminated. 2. On May 1, 2025, documentation of the identified accident was included in the Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting. The documentation confirmed that the CNA used the incorrect lift due to the family request and the incorrect number of staff to perform the transfer, despite having been trained regarding the appropriate procedure. 3. On May 1, 2025, the CEO/LNHA, Director of Nursing, and Medical Director re-reviewed the [facility name] policies on Reporting Accidents and Incidents and Transfer Techniques. No policy changes or recommendations were made because of this review. 4. On May 2, 2025, Resident #35 had a therapy evaluation completed that revealed the resident continues to require a full body mechanical lift for transfer. A meeting was held with the resident's family member, and she was informed of the findings that the resident continues to require a full body Hoyer mechanical lift for transfers. 5. On May 2, 2025, the progress notes (nurses notes) were reviewed for Resident #35 from January 11, 2025, to February 11, 2025. The progress notes did not reveal that any other staff members utilized the stand-up lift to care for the resident. 6. On May 2, 2025, Staff that cared for R#35 from January 11, 2025 to February 11, 2025, were interviewed by the Director of Nursing to determine if they cared for the resident utilizing the stand-up lift. Some staff members interviewed admitted to using the standing lift to transfer Resident #35 per the family request. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	7. From May 1, 2025 through May 2, 2025 all nursing (CNA, CMA, LVN, RN) employees, were reeducated by the Director of Nursing, Unit Manager, or Nursing Supervisors and a competency assessment was conducted for following the plan of care despite requests from family members and the location and use of the resident transfer list assignment sheet. Nursing staff (CNA, CMA, LVN, RN) working after May 2, 2025, will not be allowed to work without completion of the competency assessment. 8. On May 2, 2025, the DON, Unit Managers, and Supervisors conducted an audit to review all residents requiring the use of a mechanical lift. Point of Care documentation and progress notes were reviewed for a two-person transfer using the appropriate lift from April 1, 2025 through April 30, 2025. New residents will be assessed by therapy on admission for transfer needs and the DON, Unit Managers, MDS Coordinators, or Nursing Supervisors will update the care plan and the transfer assignment sheet at that time of the evaluation. Existing residents with changes in transfer status will be referred to therapy for an evaluation and determination of the appropriate transfer method. At that time the DON, Unit Manager, MDS Coordinator, or Nursing Supervisor will update the care plan and the transfer assignment sheet. Sincerely, Chief Executive Officer Monitoring of the plan of removal included the following (5/2/25 - 5/4/25): Monitoring observation on 05/02/2025 4:35 PM. Observation of sit to stand mechanical lift transfer for Resident #4 by CNA B and CNA L. Resident #4 sitting in wheelchair in room. CNA B moved the lift in front of the Resident #4. Resident #4 placed her feet on the platform. CNAs placed the safety belt around the Resident #4's waist connected the loops to both hooks on both sides of the lift. Resident #4 was holding on with both hands and began to lift. CNA's checked if they were high enough Resident #4 requested to go a little higher. Resident #4 was raised a small amount higher. CNA L announced she was removing the chair and removed the chair from under the resident. The lift was turned and positioned Resident #4 over the bed at the side of the bed. Resident #4 was lowered and positioned on the side of the bed. Tolerated well by Resident #4. Record review of the Special Interview Report dated 2/12/25 indicated CNA A was suspended on 2/12/25 during investigation and terminated on 2/18/25. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of the QAPI meeting sign in sheet indicated the QAPI meeting was held on 5/1/25 at 9:00 pm for removal of the IJ. The DON, ADON, MDS Coordinators, CEO, and Medical Director attended. Record review of the PT Evaluation and Plan of Treatment dated 5/2/25 indicated Resident #35 required total assist for bed mobility and transfer activities. Hoyer lift was recommended as Resident #35 was not able to tolerate static sitting balance on the edge of the bed for more than 30 seconds. Stand up lift was not recommended. Record review of the Curriculum Specific to the Plan of Removal dated 5/2/25, indicated all nursing staff were re-educated on Following the Plan of Care Despite Family Request, Location of the Lift Assignment Sheet. Record review of the Competency Checklist for Total Mechanical Lift and Sit/Stand Mechanical Lift listed check points for pre-operations check and lift operation. Interviews were conducted on 5/2/25 - 5/4/25 with staff on all shifts (7:00 a.m. - 3:00 p.m., 3:00 p.m. - 11:00 p.m., and 11:00 p.m. - 7:00 a.m.) and included RN B, RN C, LVN A, LVN B, LVN C, LVN D, CMA A, CMA B, CMA C, CNA B, CNA D, CNA E, CNA F, CNA G, CNA H, CNA I, and CNA J to verify the in-services were conducted and to validate the staff understanding of the information presented to them. Nursing staff knew where to locate the transfer lift assignment sheet for the [NAME] and [NAME] Units. Nursing staff knew what to do in the event a new resident came into the facility and the resident was not listed on the assignment sheet. Nursing staff knew to follow the care plan despite any requests from family members regarding using the type of lifts. Nursing staff knew mechanical lifts required 2-person assist. The Chief Financial & Administrative Officer was notified on 5/4/25 at 12:22 p.m., the Immediate Jeopardy was removed. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place. 2. Record review of Resident #1's undated face sheet reflected Resident #1 was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included: dementia (confusion and forgetfulness), acute kidney failure (kidneys suddenly cannot filter waste from the blood), weakness, and syncope and collapse (loss of consciousness). Record review of Resident #1's Quarterly MDS Assessment, dated 03/13/2025, reflected Resident #1 had a BIMs score of 4, which indicated severe cognitive impairment. Record review of Resident #1's revised care plan, dated 10/09/24, reflected that Resident #1 had cognition loss, confusion, and poor judgment. The interventions included no harm/injury. Record review of Resident #1's Elopement Risk Assessment completed on 03/25/2025 indicated that she was not a high risk for elopement and did not display any abnormal behaviors or exhibit a change of mental status prior to elopement. Record review of Resident #1's physician orders reflected a new order on 03/26/25 for placement of the Wander guard. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #1's progress note dated 03/25/2025 at 9:30 PM, written by LVN A, revealed that Resident #1 was observed sitting in a wheelchair in the facility's parking lot at 8:45 PM by another resident's family member. The family member returned Resident #1 to the facility, and the supervisor and RP were notified of the incident. During an observation and interview on 05/01/2025 at 12:05 PM Resident #1 was alert and oriented lying down in bed and said she did not remember the incident. During an interview on 04/30/25 at 3:39 PM, CNA V said she was informed that Resident #1 was looking for her family member and was found outside the facility. She said she was a very confused resident who normally stays in her room. She said the doors were monitored by security when she leaves at 11 PM, so she was unsure how the resident could get out. She said the risk to the resident was that the resident could fall out of her wheelchair, or someone could harm her. She said she was in-serviced on 03/28/25 on elopement because Resident #1 was found outside of the facility. During an Interview on 04/30/25 at 4:12 PM, CNA C said she works the 3-11pm shift but was not at work when Resident #1 was found outside. She said she was in-serviced on elopement in March after the incident and was in-serviced on abuse and neglect approximately 1-2 weeks ago. She said the risk to the resident being found outside in the parking lot was that she could get injured. Attempted telephone interview on 05/01/25 at 9:03 AM with RP, surveyor left a voicemail. During an interview on 05/01/25 at 2:44 PM, the ADON said she left around 7-8 PM on the day of the incident and denied any change of condition with Resident #1. She said she was not exit-seeking before incident and was not at high risk for elopement. She said Resident # 1 was confused and forgetful and preferred staying in her room. She said the NP, RP, and DON were notified on the day of the incident. She said the NP ordered a Wander Guard that was placed on the resident's wheelchair. She said the Wander Guard was recently removed after frequent monitoring, and it was found that the resident was no longer exit-seeking. She said that it was not safe for a resident with cognition concerns to leave because they could get injured, or someone could harm them. During an interview on 05/01/25 at 3:19 PM, LVN A said she was familiar with Resident #1 and remembered the incident in March when she was found outside in the facility's parking lot. She said the resident went downstairs that day, and a family member saw her in the parking lot and brought her back into the facility. She said she did not know how long she was outside but remembered seeing her in the hall 1 hour prior to returning to the floor. She said when she returned to the floor, she did a head-to-toe assessment, and no injuries were noted. She said she also did every 30-minute observation for her shift, and labs were drawn. She said the NP, RP, and DON were notified of the incident immediately. LVN A denied that the resident was exit-seeking before or after the incident. She said the risk of her leaving the facility was falling out of the wheelchair or someone harming her. During an interview on 05/01/25 at 3:43 PM, the administrator said the resident was talking with the security guard in the lobby at 8:30 PM. She stayed in the lobby for 5 mins (8:35 PM). She said she watched the video and could see the security guard on the phone and watching the resident on the camera. She said another resident's family member brought the resident back into the facility at 8:50 PM. She said the facility did an in-serviced after the incident on elopement, and the security guard on duty was not allowed to return to the facility. She said they also had other security staff in-serviced and educated on elopement procedures and protocols before they could work at the facility. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an Interview on 05/01/25 at 4:09 PM, CNA K said she was not assigned to Resident #1 on the day of the incident. She said that she was aware that the resident went downstairs and was found outside of the facility. She denied having any elopement concerns with Resident #1 before or after the incident. She said after the incident the staff was trained to notify the charge nurse/supervisor if there was a missing resident. CNA K said the risk of having an elopement was that Resident #1 could fall out of the wheelchair and injury herself. During a telephone interview on 05/04/25 at 9:40 AM, the RP said the facility called him between 8 and 9 PM to inform him that Resident #1 was found outside the building. He said he was surprised because she had never tried to leave the facility before and preferred to stay in her room. He said he was also surprised because security was always at the front desk at 8:00 PM, and he was not sure how she could leave the facility. The RP denied injury to Resident #1 and said a wander guard was placed on her w/c that was recently removed. Observation on the facility's security camera on 05/04/25 reflected: 03/25/25 at 8:35PM: Resident #1 left out of the facility's doors leading outside in her wheelchair following behind another resident's family member. 8:38PM: The family member who initially left returned to the front desk by the security guard and points towards outside. 8:39PM: The security officer can be seen checking the security cameras and calling on the phone. 8:43 PM: The resident can be seen via the outside security cameras in the parking lot sitting in her wheelchair. 8:44PM: The security officer goes outside to check on resident at the edge of the driveway, bending over next to the resident. 8:48 PM: The security officer returns and can be seen looking through a binder and using the phone. 8:49 PM: another resident's family member wheels Resident #1 back into the facility lobby. Record review of the facility's policy titled Wandering and Elopement of Residents revised 10/13/2023, read in part . Policy: To attempt to maintain the safety of our Residents, while allowing them maximum independence. Potential Risks for Wandering and Elopement: 2. Residents who have dementia/Alzheimer .