STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676160	A. Building B. Wing	06/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingwood Rehabilitation and Healthcare Center	23775 Kingwood Place Kingwood, TX 77339

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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** Based on observations , interview and record review the facility failed to ensure the resident environment remained as free of accident hazards as possible and that each resident received adequate supervision and assistance devices to prevent accidents for 2 out of 11 residents (CR#1 and Resident # 58) reviewed for adequate supervision and accident hazards. -CR #1 left the faciity on [DATE] around 5:45pm and the facility was not aware of CR #1's whereabouts until 06/20/2025 at 8:42pm when they received notice CR #1 was found walking on the road near the facility . This was determined to be an IJ on 6/26/25 for CR #1's elopement. The Administrator and DON were notified on 6/26/25 at 4:23pm. The DON and Administrator were provided with the IJ template on 6/26/25 at 4:27pm and a Plan of Removal was requested. The IJ was lowered on 06/29/2025 at 11:40am with the Administrator and DON, While the IJ was lowered, the facility remained out of compliance at a scope of isolation and a severity of harm with potential for more than the minimal harm that is not an immediate jeopardy because the facility's need for continued monitoring of implemented procedures. -There was an empty O2 tank sitting on the floor unsecured in Resident # 58's room. This deficiency exposed residents living in the facility to potential harm, injury or death due to not being adequately monitored. Findings: CR #1 Record review of CR #1's face sheet dated 06/25/2025 reflected an [AGE] year-old female originally admitted to the facility on [DATE] and last re-admitted on [DATE]. Her medical diagnoses included Alzheimer's Disease (a neurodegenerative disorder which causes decline in memory, thinking and behavior), Type 2 diabetes mellitus (high blood sugar), chronic kidney disease, Major Depressive Disorder (a serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities which disrupts the ability to function in everyday life), Hypertension (high blood pressure), overactive bladder, Dementia (a general term to describe decline in cognitive function, memory loss, difficulty communicating, impaired reasoning and changes in personality), and insomnia (difficulty or inability to sleep). (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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR #1's Quarterly MDS dated [DATE], CR #1 had a BIMS score of 6, indicating severe cognitive impairment. CR #1 required partial to moderate assistance with her ADLs including oral and personal hygiene, dressing, showering or bathing, and toileting. She required setup assistance for walking from 10 to 50 feet and supervision for walking 150 feet. CR #1 was frequently incontinent with urine and occasionally incontinent with bowel. Record review of CR #1's care plan captured 06/25/2025, she was care-planned for elopement on 6/20/25, with interventions including 1 to 1 assistance, anticipating and meeting resident needs and explaining/reinforcing why behaviors were inappropriate and/or unacceptable to the resident. CR #1 was not previously care-planned for being at risk of elopement. Record review of CR #1's Kardex care sheet, undated, CR #1 had interventions for staff to report any attempts to exit the facility to the IDT, family and MD as indicated and record in the clinical record. She was also planned for IDT care plan over the phone with resident's RP to review current placement versus close/lock unit due to resident recent elopement. Record review of CR #1's progress notes, on 6/20/2025 at 1:34am she was resting in bed with no distress noted. On 6/20/2025 at 8:41pm, the DON was notified via phone that CR #1 was sitting on the floor by her walker near a college and taken to the ER. RP was notified 6/20/2025 at 9:01pm. On 06/21/2025 at 2:57am, a nurse documented that CR #1 was ordered to be on 1-to-1 supervision when she returned to the facility. CR #1 had returned from the hospital around 4:45am that day. A later note at 1:27pm, CR #1 was documented as being one-on-one care with aide due to an elopement on 6/20/2025 and CR #1 door was open, and resident was able to come in and out with supervision. Further review showed from September 2024 to June 2025, CR #1 was not mentioned having any exit-seeking or elopement incident. Record review of CR #1's elopement risk assessments completed 1/15/2025 and 3/19/2025, the assessments reflected CR#1 had a history of elopement or attempted to leave the facility without informing staff. No interventions were selected for either assessment. An additional elopement risk assessment was completed 06/12/2025 which reflected that CR #1 was marked yes for verbally expressing desire to go home, packing belongings or stayed near the exit, and there was a note reading usually resident sits at the lobby. CR #1 was also selected yes for having Alzheimer's, being cognitively impaired with poor decision-making skills related to intermittent confusion, cognitive deficits or disorientation, ambulating independently and had a walker. Record review of CR #1's psychology assessment on 06/3/2025, CR #1 was seen in her room and reiterated she continued to miss her family and would like to be home with them. Record review of CR #1's skilled nurse charting on 06/21/2025, CR #1 was on 1-on-1 care with an aide due to elopement on 06/20/2025. Record review of CR #1's pain assessment done on 06/21/2025, CR #1 stated not being in pain. Record review of CR #1's skin evaluation done on 06/21/2025, CR #1 refused full body skin assessment, staff evaluated CR #1's upper and lower extremities only with no injuries. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR #1's 15-minute check sheet for 6/21/2025, she was monitored and staff signed off on her for reasons of fall between 6/21/25 at 4:45am to 9:00pm before being transferred to the hospital. Record review of CR #1's hospital records dated 06/21/2025, CR #1 was found by a bystander who called emergency services when she was found walking unsteadily on the road. Bystander assisted CR #1 to the side of the road until law enforcement came. CR #1 was witnessed falling twice and denied hitting her head or loss of consciousness. CR #1 was brought to the hospital after bystanders saw her acting confused. CR #1 complained of back and neck pain. CR #1 was seen for a fall, AMS and found walking on the road. CR #1 reported chronic lower extremity swelling and the hospital documented CR #1 with pain level of 6. CR #1's CT scan had no acute findings. CR #1 had right leg pain and UTI (asymptomatic). Record review of CR #1's Order Summary dated 06/25/2025, there were no orders for monitoring due to wandering or exit-seeking. CR #1 had orders for Aricept Oral Tablet 10 MG with an order date of 5/21/2025 for dementia, Divalproex Sodium Tab Delayed Release 125 MG with a start date of 11/6/24 for mood disorder, and Escitalopram Oxalate Tab 10 MG with a start date of 11/6/24 for Major depressive disorder. In an interview on 06/25/2025 at 11:40am with CR #1's RP, she said she received a call on 06/202/25 on 9:49pm stating that CR #1 walked out of the building, was fine and going to the hospital. She said when she spoke to staff at the hospital stated her mom was there for 2 hours already and CR #1 was covered in feces. The RP said CR #1 reported to her that she fell in the street. She said the doctor said she had an X-Ray and CT scan completed and the hospital discharged CR #1 back to the facility on [DATE] at 5:00am. Interview on 05/26/2025 at 1:20pm with CNA GG, CNA GG worked at the facility since March 2025 and worked 6am-2pm and 2pm-10pm as needed. CNA GG was not working at the facility when CR #1 eloped and had never seen CR #1 leave before but said CR #1 was always wandering and walking down one particular hall. CNA GG said staff are to round on residents at least every two hours and had in-services on elopement and residents with dementia after the elopement. Interview on 05/26/2025 at 1:29pm with CNA O, CNA O was assisting in the dining room on 06/20/2025 when CR #1 eloped. CNA O received notification CR #1 was missing between 7pm-8pm that same day. CNA O never heard CR #1 saying she wanted to leave the facility. Staff should round every two hours and CNA O rounds every 30 minutes to 1 hour. If a resident was missing, CNA O would try to look for them and if unsuccessful would report the missing resident to the nurse, charge nurse and Administrator immediately. CNA O had an in-service on elopement after CR #1's elopement. Interview on 05/25/2025 at 1:39pm with CNA P, CNA P worked the morning shift on 06/20/2025 and did not see CR #1 leave the facility. The last time CNA P saw CR #1 was around 2:00pm at the end of CNA P's shift. CNA P never saw CR #1 try to leave or vocalize the desire to leave the facility. CNA P did 1-to-1 monitoring for CR #1 when CR #1 was re-admitted to the facility on [DATE].CNA P received 1-to-1 and facility-wide in-service about the elopement policies and procedures after CR#1's elopement. CNA P said she had received in-services on resident elopement and resident with dementia since working at the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 06/25/2025 at 2:00 PM CNA GP, she stated she had been working at the facility for 3 years. CNA GP said she was not present at work when CR #1 eloped. CNA GP said CR #1 would like to stay in her room a lot but, would come out her room for coffee and activities, and that she was mobile with her walker. CNA GP said CR #1 would say she wanted to go home often and be with her family. She said the hallway exit doors are all locked and would set off the alarms, but the front door to the facility was not locked but now are locked since CR #1 eloped. CNA GP said the front door is important with lots of traffic after dinner because families leave out and sometimes will hold the door open for residents thinking they are okay to be outside alone. She said she doesn't know all the details but believed CR #1 went through the front door. CNA GP stated she has no concerns of any abuse, neglect, or elopement at the facility. In an interview on 06/25/2025 at 3:00 PM with NP B stated she was shocked that CR #1 left the community as CR #1 was not an elopement risk and she was not care-planned for elopement because NP B had not witnessed or heard CR #1 wanting to leave the community. NP B said she was not concerned about change of condition for CR #1 and was aware the results from the hospital returned negative. NP B said CR #1 was mobile with her walker and was active with therapy services and that CR #1 was normally calm and to herself and liked to eat lunch in her room. NP B stated the community was not a restraint/ locked community and did not utilize a wander guard system. NP B said staff were not aware that CR #1 was exit seeking. Staff had been in-serviced since the incident and an alarmed keypad has been implemented to the front door. Interview on 05/25/2025 at 3:05pm with LVN I, LVN I said CR #1 walked around a lot depending on her mood and would sit at nurse's station. In the past, CR #1 would sometimes walk up to and rattle the double doors and staff had to redirect her, but this was not recent. LVN I said CR #1's family was aware of this. LVN I was not there when CR #1 eloped. LVN I had received in-services on resident elopement and resident with dementia before and after CR #1's elopement but she did not remember the dates. CR #1 had never gotten out of the facility so LVN I did not know if risk of elopement would be care-planned but knew that CR #1 was assessed for elopement risk. LVN I did not know CR #1's risk score. Interview on 06/25/2025 at 2:54pm with CNA C, CNA C heard that CR #1's exit-seeking behavior had been going on for some time and staff would redirect her back. CNA C had seen CR #1 in the dining room eating on 6/20/2025 at 5:30pm to 5:40pm and CNA C was taking another resident to their room. CNA C had been notified CR #1 had left around 7:30pm-8:30pm during last rounds. CNA C said when CR #1 came back to the facility she was observed trying to leave the building again. CNA C received in-services on resident elopement and resident with dementia. CNA C would report elopements or missing residents and report it to the charge nurse and document it. CNA C would redirect residents back to the facility if she saw them leave. (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 06/25/2025 at 3:44pm with the Administrator and DON, the Administrator said she was the Interim Administrator and began work on 06/02/2025 and the DON was Interim and had started working in the building at the end of May 2025. The Administrator said that her investigations found that CR#1 left unassisted. CR #1 told the Administrator she wanted to walk by the college to the hospital. The Administrator said an aide last saw CR #1 on 6/20/2025 around 5:45pm in the front lobby and a CMA last gave CR #1 medication at 6:00pm but the Administrator could not remember who the CMA was. The DON received a phone call from the facility's Marketing Director on 6/20/2025 at 8:45pm that a bystander found CR #1 walking down the road, and that bystander called the Marketing Director to see if CR #1 was a resident at the facility. The DON then told the Administrator and the Quality Assurance Nurse who were both still in the building. The facility did a head count, and the DON called CR #1's doctor and RP after speaking to the bystander to locate CR #1. The bystander told the DON that CR #1 was on the floor near the college and was with the bystander and another unidentified male. CR #1 had an incontinent episode. The bystander reported that she called EMS who came and took CR #1 to the hospital. The DON said the hospital did not report any injuries, and CR #1's blood and UA tests came back negative, and CR #1 was discharged back to the facility. When CR #1 came back to the facility she reported wanting to leave again and became agitated, so she was placed on 1-to-1 monitoring every 15 minutes before she was moved to a hospital psych unit for treatment. The Administrator and DON were not aware CR # 1 was an elopement risk. The DON said CR #1 was later assessed and found to be an elopement risk, and she was placed in the elopement binder. The DON had about 5 residents who have wandering behaviors, but none expressed wanting to go out and leave the building. CR #1's RP told the Administrator and DON after the elopement incident that CR #1 was found having left the building in the past, but no date was clarified. The Administrator said the front doors locked at 7pm daily. After CR #1's elopement, the Administrator put red boxes on all facility doors including the front door so if anyone tried to open the door the alarm would activate. The DON said the facility notified the family members regarding the new alarm system and if families wanted to visit after hours to call the phone number located on a sign at the front door. The Administrator and DON in-serviced staff to not share the code to the doors. The DON said the facility had no elopements since this incident. The DON said risk of elopements should have been in the care plan but the facility was previously under a different company so all of the old care plans might not have transferred over like for CR #1. The DON said there was an elopement binder already, but after CR #1's elopement assessed all current residents for elopement again and updated the binder. The DON said there were no wander guards, and the facility would not be able to accept CR #1 again because she was a fast walker, could walk on her own and was adamant about leaving. The bystander's information was requested from the DON, but it was not provided by survey exit. Interview on 06/26/2025 at 10:31am with LVN FZ, he said on 06/20/2025 he got to work early at 5:20pm and remembered seeing CR #1 in the lobby. LVN Z did not report to work until 6:15pm after a meeting. He did not hear about CR #1 being an elopement risk, and that he would get that information through reports. If a resident tried to leave he would redirect them to their rooms and ensure their safety, then assess, document and report the incident to someone in Administration. LVN FZ would check all the rooms and bathrooms and if the resident could not be found LVN FZ would call the DON and Administrator. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's policy on elopement and wandering residents last reviewed or revised 06/2025 read in part, The facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk .the facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness . Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicate with appropriate staff . Record review of the facility's policy on documenting in the medical record last reviewed or revised 04/2025 read in part, Each resident's medical record shall contain an accurate representation of the actual experience of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation .Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record . Record review of the facility policy and procedure entitled, Accidents and Supervision date revised 1/25 read in part . The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes Identifying hazard(s) and risk(s) .Evaluating and analyzing hazard(s) and risk(s) .Implementing interventions to reduce hazard(s) and risk(s) .Monitoring for effectiveness and modifying interventions when necessary . All staff (e.g., professional, administrative, maintenance, etc.) are to be involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident. Record review of the facility's policy on routine resident checks last reviewed or revised 04/2023 read in part, Staff shall make routine resident checks to help maintain safety and well-being. This was determined to be an IJ on 6/26/25 for CR #1's elopement. The Administrator and DON were notified on 6/26/25 at 4:23pm. The DON and Administrator were provided with the IJ template on 6/26/25 at 4:27pm and a Plan of Removal was requested. The IJ was lowered on 06/29/2025 at 11:40am with the Administrator and DON, While the IJ was lowered, the facility remained out of compliance at a scope of isolation and a severity of harm with potential for more than the minimal harm that is not an immediate jeopardy because the facility's need for continued monitoring of implemented procedures. The following plan of removal was accepted on 6/27/25 at 11:11am. PLAN OF REMOVAL [Name of facility] Date: 06/26/2025 F689- Accidents/supervision Problem: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility failed to ensure CR #1 received adequate supervision to prevent elopements after she eloped from the facility on 06/20/2025 and was last accounted for at 5:50pm. CR #1 was located by a bystander who saw CR #1 walking down the street from the facility and called emergency services and CR#1 went to the hospital. Immediate action: 1. 6/20/25 The facility administrator completed a self-report incident to HHSC due to resident elopement. 2. 6/26/25 The facility DON/Designee conducted an audit of residents with high risk for Elopement risk based on updated assessment and history of exit seeking behaviors. 7 residents identified to be at risk. All included in the Elopement Binder. Completed 6/27/25 3. On 6/26/25 The VP of Clinical Services conducted a 1:1 in-service with the Admin and DON on the facility Elopement Policy focusing on timely implementation of interventions aimed to prevent and mange residents with wondering and exit seeking behaviors, to include adding chosen interventions to the person center care plans. Interventions: 4. On 6/26/25 the Administrator/designee repeated an elopement drill with all facility departments staff, evening, night and day shifts to ensure understanding of the process. This included a review of the Elopement Binder, identification of exit seeking behaviors and interventions to immediately implement such as 1:1 supervision. Staff was instructed to utilize the Elopement binder/The resident care profile and the Kardex to identify residents at risk for Elopement/exit seeking episodes. Complete 6/27/25 5. On 6/26/25 the Administrator/Designee initiated an in-service with all facility staff on elopement policy and procedure and residents rights to ensure staff understands all residents have the rights to have adequate supervision. Completed 6/27/25 6. On 06/26/25 the DON/Designee initiated an in-service with nursing staff on immediately reporting all resident exhibit exit seeking behaviors to the Administrator and interim DON to seek guidance and ensure appropriate interventions are put in place following a resident's exit seeking behaviors. Projected completion 6/27/25. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. On 6/26/25 The facility front door is scheduled to be automatically locked from 5pm to 8am. Staff was promptly in-service by the DON/Designee on the door locking scheduled and code 6/26/25. Projected completion 6/27/25. 8. On 6/26/5 the facility maintenance director re-in-service all staff on how to activate and deactivate the alarm upon sounding with a key, a key will be kept with each floor nurses and the DON. Upon sounding of the alarms staff was instructed to assess the area for residents and conduct a head count upon the sounding of the alarm. The nurse will immediately initiate code white with any missing residents. 9. On The Administration/designee conducted a resident council meeting to make them aware of the changes to the doors as well as the front door automatic locking times. Ongoing Projected Completion 06/27/25 Any staff member not present or in service will not be allowed to assume their duties until in-serviced. Ongoing In-service will be completed by DON/ADON/WC NURSE/or weekend nurse supervisor, until all staff, weekend, prn, and agency staff in completed. Monitoring 10. On 06/25/25 The interim DON/designee began a questionnaire to validate the effectiveness of the training. The questionnaire is conducted with facility staff. Immediate re-education will be completed by the interim DON/designee if any staff are unable to answer appropriately the questions on the questionnaire. Staff will not be allowed to work until after completion of the questionnaire. Projected completion 06/27/25 11. An impromptu QAPI meeting was conducted with the facility's Medical Director on 06/26/25 to notify of the potential for non-compliance and the action plan implemented for approval. Plan approved on 06/26/25. Monitoring/Observations/Interviews/Record reviews: Record review of the IJ binder: - On 6/20/25 the facility administrator completed a self-report incident to HHSC due to CR #1's elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On 6/26/25 The facility DON/Designee conducted an audit of residents with high risk for Elopement risk based on updated assessment and history of exit seeking behaviors. 8 current residents identified to be at risk and their face sheets were included. -In-service records on elopement, elopement and wandering, possible exit-seeking behaviors and reporting to the Administrator and DON, and resident rights policy were reviewed and signed by staff from all departments. The Administrator and DON received and signed for in-services on 06/26/2025 from the VP of Clinical Services on Elopements and Wandering Residents. -A copy of the drill for locating missing residents titled Alert Code WHITE which listed staff disciplines and their corresponding responsibilities. -A copy of the Elopement Incident Search Assignment blank form which listed sectors on the premises with staff assigned and post-search report and time columns. -A copy of the Missing Resident Audit which was a check-off list for staff if a resident was missing. -A copy of the Critical Behavior Monitoring Log listing 15-minute intervals and space for staff to initial resident observations. -Proof of purpose and installation date of the 365-day 24-hour timer/controllers for the front door were installed on 06/22/2025. -Resident Council Meeting sheet addressing door alarm and signed by residents in attendance. -Elopement Training Validation Questionnaires completed and signed by staff on 06/28/2025 with questions including elopement prevention measures, codes to call, and who to notify after an elopement completed by 06/28/2025. -IJ Template signed by the DON. The Template had a note reflecting that a QAPI Meeting was held with the Medical Director on 06/26/2025 at 4:45pm. -The QA Meeting summary sheet dated 06/26/2025 listing out steps the facility took after the elopement and signed off by the Medical Director, Administrator, Director of Nursing, and IDT staff member. Observations of resident hallways, primary and secondary alarms showed active and locked. Interviews on 06/29/2025, residents said they felt safe and comfortable at the facility, had their call lights answered in a timely manner and all services provided. Interview on 06/28/2025 at 1:18pm with CNA D, she received in-services on elopement, which included reporting elopements to the Administrator/Abuse Coordinator and the DON, how the new alarm system worked and what to do during a Code [NAME] elopement incident. CNA D said ways to prevent elopement included getting residents involved in activities and redirecting them to other things. If a resident is missing, one person from each hall will coordinate the search and if the resident is still missing to contact the Administrator and family. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676160	A. Building B. Wing	06/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingwood Rehabilitation and Healthcare Center	23775 Kingwood Place Kingwood, TX 77339

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 06/28/2025 at 1:26pm with CNA V, she received in-services on elopement and the alarm system. If a resident was walking to the door, CNA V should let a nurse know and to keep an eye on the resident. If a resident eloped, she would do a head count and let everyone know, including nurses and the Administrator. CNA V was also in-serviced all doors in resident hallways were locked 24/7. Interview on 06/28/2025 at 1:43pm with LVN AA, she received in-services on protocols on elopement, elopement prevention and exit-seeking behaviors and how to reset the alarm. LVN AA said nurses had a key to reset alarms if it went off, if residents were missing staff should spread out and attempt to locate the resident and after 30 minutes if resident is still missing staff should notify the Administrator and DON. If a resident was wandering toward the door, they should be placed under 1-to-1 monitoring and the family should be notified. Staff should keep an eye on residents and lay eyes on residents every two hours. LVN AA said residents' exit-seeking behaviors should be in their care plan and in their orders for monitoring of exit-seeking behaviors. Interview on 06/28/2025 at 2:07pm with the Quality Assurance Nurse, she said she received and conducted in-services for staff on elopement. The Quality Assurance Nurse covered topics such as exit-seeking behaviors like forcing doors open and verbalizing things like having to go home to their kids and staff should redirect if they can and service on the second alarm system which was an additional layer to the 15-second delay on hallway doors. Staff were also trained on the code white drill for elopement and the facility conducted an elopement drill. The Quality Assurance Nurse said the eight residents in the Elopement Binder were identified as high risk because they had verbalized wanting to go home. The Quality Assurance Nurse said floor nurses did not do care plans, but MDS Nurses and nurse managers could. Interview with the MDS Consultant on 06/28/2025 at 2:13pm, she said she received elopement and changes in condition in-services. The MDS Consultant learned about the process of elopement such as the code and alarms, head counts, and notifying the Administrator, DON, physician and family when there are changes in condition such as an elopement. Interview on 06/28/2025 at 11:44pm with CNA MM, she worked from 10pm to 6am. She received in-services on elopement and care plans. Signs of elopement included verbalizing the desire to leave and going towards the exit door. If CNA MM saw a resident do these things, she would bring them back and keep an eye on them and tell the nurses. CNA MM also received in-services on the elopement drill and codes. Interview on 06/28/2025 at 6:40pm with RN TT, she worked night shift and received in-services on elopement and wandering residents and care plans and that she should report any signs of elopement such as residents asking to go home to the doctor, family and management. She said incidents should be documented and nurses should make a report. RN TT had in-services on how the alarm system worked. Interview on 06/28/2025 at 7:33pm with LVN PP, she worked night shift and said information on a resident's elopement risk would be in the Elopement Binder at the nurse's station. LVN PP was in-serviced on monitoring residents if they showed signs of exit-seeking and to assign someone to monitor 1-on-1 and inform the Administrator, DON, the physician and the resident's RP about attempts or actual elopements. All nurses had a key to the door alarm systems. LVN PP received an elopement drill. (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 06/28/2025 at 10:16pm with CNA IM, she said she received a list of residents with elopement risks, elopement drills, and exit-seeking prevention strategies like monitoring, checking doors, and providing activities to keep residents occupied. Signs and symptoms of exit-seeking were talking about eloping, bringing up old memories and wandering. If CNA IM saw a resident elope, she would report it to the charge nurse, and she could find the information in the resident's medical chart and Kardex. CNA IM said staff should round every 1-2 hours on residents. Interview on 06/28/2025 at 11:48pm with LVN OO, she said she was an agency staff and worked night shift. LVN OO had in-services and huddles on elopement and care-plans. During an elopement, nurses should print out the census and check on rooms. LVN OO received an elopement drill training. If a resident stated leaving or packing up room, staff were to redirect residents and let their supervisor know, do a change in condition assessment and let the Administrator, DON, the physician and family know. LVN OO said staff could look at white binder for elopement risk residents with facesheet, and also look in the resident's medical chart for demographics, special interventions, care plans, and rounding every 2 hours unless residents had a special care plan requiring more frequent rounding. Interview on 06/29/2025 at 9:31am with CNA J, he worked from 10pm to 6am and received in-services on elopement and the alarm systems. CNA J would report to the nurse if residents mentioned wanting to go home and taking transportation. CNA J would redirect residents back to their room if he saw them wandering or [TRUNCATED]