STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676239	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Toscana at Cypress Woods	15015 Cypress Woods Medical Dr Houston, TX 77014

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	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** 47572 Based on observation, interview, and record review the facility failed to ensure the resident environment remained free of accident hazards as possible, and each resident received adequate supervision and assistance devices to prevent elopement for two of seven residents (Resident #4 and Resident #5) reviewed for accident hazards and supervision. -The facility failed to ensure Resident #4 had adequate supervision on 4/5/2024 and 4/30/2024 which allowed her to elope from the facility's memory care unit. -The facility failed to ensure Resident #5 had adequate supervision on 4/30/2024 which allowed her to elope from the facility's memory care unit at a different time from Resident #4. -The facility failed to ensure the memory care unit's secured doors remained secured on 4/5/2024 and 4/30/2024 allowing two residents to elope. The noncompliance was identified as PNC and the Administrator was given the I.J. Templae on 8/9/24 at 2:15 p.m. The IJ began on 4/5/2024 and ended on 4/30/2024. The facility had corrected the noncompliance before the survey began. These failures could place residents at risk of serious injury or harm. Findings include: Resident #4 Record review of Resident #4's face sheet revealed an [AGE] year-old woman admitted on [DATE]. The face sheet documented her diagnoses included lack of coordination, dementia (general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), malnutrition (a condition that occurs when a person's intake of energy and nutrients is deficient, excessive, or imbalanced), anxiety disorder (mental health conditions that cause excessive fear, worry, and other feelings of dread and uneasiness), TIA (medical emergency that occurs when blood flow to the brain is temporarily disrupted, causing a lack of oxygen to the brain), difficulty walking, restlessness and agitation, and adjustment disorder (condition in which a person has an unhealthy or excessive emotional or behavioral reaction to a stressful event or life change within three months of it happening). (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 Resident #4's admission MDS dated [DATE] with an ARD of 4/14/2024 revealed a BIMS score of 8 indicating significant cognitive impairment. The MDS documented she had no potential indicators of psychosis, behaviors affecting others, or rejection of care. Per the MDS, Resident #4 had wandering behaviors daily during the review period. The MDS revealed she had an impairment of one lower extremity, and she used a walker for mobility. The MDS documented she required supervision or assistance with all ADL's except eating. Per the MDS, Resident #4 received OT services. Record review of Resident #4's care plan dated 4/18/2024 revealed a focus on her admission to the secure unit due to her dementia diagnosis and elopement risk with interventions including monitoring for possible off unit activities, monitoring for signs of depression, and monitoring and reporting any changes of condition. The care plan documented a focus on her risk of wandering with interventions including distraction from wandering, monitoring and identifying a pattern of wandering, remaining with her when she was exit-seeking, providing her with structured activities, and ensuring she remained on the secure unit. The care plan included a focus on her previous attempts to exit the facility with interventions including assessing and reporting factors leading to her elopement, close supervision, providing structured activities, and remaining with her if she was exit-seeking. Per the care plan, she was found outside the facility and returned with no injuries. Record review of Resident #4's nurse's note dated 4/5/2024 revealed she had been found outside the facility on the street leading away from the facility at approximately 7:45 PM. The note documented she was provided with food and water, and she was assessed. Per the note, Resident #4 said she was looking for her family member but was unable to find her. Record review of the facility's Provider Investigation Report (PIR) dated 4/12/2024 for Intake ID 495508 revealed Resident #4 had eloped from the facility shortly after 6:00 PM on 4/5/2024. The PIR documented the nurse on duty had last had contact with Resident at approximately 6:00 PM on 4/5/2024. Per the PIR, at approximately 7:45 PM on 4/5/2024 a staff member from an adjacent business called the facility and reported Resident #4 had been found walking on the street near the facility, walking towards a major thoroughfare. The PIR revealed the staff member from the adjacent business was able to coax Resident #4 into the staff member's car and bring her back to the facility. The report documented the facility had an outside vendor and staff ensure all doors were working properly after the incident. Interview on 8/9/2024 at 2:14 PM with the Admin, who said her expectations for a resident elopement were that staff would complete an internal and external search of the facility and call a code orange. The Admin said she expected that staff would search further from the facility to the major thoroughfare approximately a half mile away. The Admin said she expected that when staff heard a door alarm sound the staff would immediately go to the door, visually assess the outdoor area near the door, ensure no one exited the facility, inform the charge nurse, and the charge nurse would complete a headcount. The Admin said during a power outage, all staff were required to go to a specific door until the power returned or the backup generator provided power to the doors, and they were manually reset. The Admin said the plastic covers were installed over the emergency door release buttons near the two nurses' station after the incidents in April, the emergency door release button cover had been installed on the emergency door release in the memory care unit prior to her onboarding, the facility had one reset button for all the doors near the nurse's station on the skilled nursing side of the building and would be installing another one near the nurses' station on the long term care side so staff could reset from each side of 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	Record review of Resident #4's nurse's note dated 4/30/2024 revealed that the staff was unable to find her on the hall or other halls at approximately 8:46 PM. The note documented the DON at the time was notified that Resident #4 was missing. Record review of Resident #4's behavior note dated 5/20/2024 revealed she was exit-seeking. The note documented she said she wanted to leave, and the facility was holding her against her will. Per the note, Resident #4 picked up a trash can, hit the window with the can, pulled a staff member's hair, and punched a staff member. Record review of Resident #4's nursing note dated 7/19/2024 revealed she was pounding on the door in the secure unit attempting to leave. Record review of Resident #4's elopement risk assessment dated [DATE] revealed she was an elopement risk. Record review of Resident #4's elopement risk assessment dated [DATE] revealed she was an elopement risk. Record review of Resident #4's elopement risk assessment dated [DATE] revealed she was an elopement risk. Observation on 7/5/2024 at 2:35 PM revealed Resident #4 was in the activity room of the memory care unit engaged with other residents. Observation on 8/9/2024 at 9:54 AM revealed Resident #4 was in her bed sleeping. Resident #4 appeared dressed and appropriately groomed. Resident #5 Record review of Resident #5's face sheet dated 7/5/2024 revealed a [AGE] year-old woman admitted on [DATE]. The face sheet documented her diagnoses included encephalopathy (any disease, disorder, or damage that affects the structure or function of the brain), epilepsy (chronic neurological disorder of the brain that causes people to have recurrent, unprovoked seizures more than twenty-four hours apart), difficulty walking, dementia (general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), brief psychotic disorder (psychotic condition that begins suddenly and lasts for at least one day but less than one month), generalized anxiety disorder (mental health condition that causes excessive, persistent, and unrealistic worry about everyday events and situations), adjustment disorder (condition that occurs when an individual has an emotional or behavioral reaction to a stressful event or life change that is considered unhealthy or excessive), and kidney failure (occurs when the kidneys are unable to function properly and remove waste and extra water from the blood, or maintain the body's chemical balance). (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 Resident #5's quarterly MDS dated [DATE] with an ARD of 4/22/2024 revealed no BIMS was completed as she was unable to complete the interview. The MDS documented she had inattention and disorganized thinking. Per the MDS, Resident #5 had no potential indicators of psychosis, behaviors affecting others, rejection of care, or wandering behaviors. The MDS revealed she had no impairments of her upper or lower extremities, and she used a walker for mobility. The MDS documented she required supervision or assistance with all ADL's except eating. The MDS revealed she received OT services.

Record review of Resident #5's care plan dated 4/1/2024 revealed a focus on her risk of wandering with interventions including a fall risk assessment, distracting her form wandering, identifying a pattern of wandering, remaining with her when she was exit-seeking, and providing her with structured activities. The care plan documented a focus on her elopement risk with interventions including ensuring she resided on the secure unit, assessing for potential elopement causes, providing structured activities, and distracting her. Per the care plan she was found out of the secured unit and returned on an unknown date.

Record review of Resident #5's nurse's note dated 4/30/2024 at 9:04 PM revealed a CNA could not locate her on the secure unit. The note documented she was not found on the secure or other units. Per the note, the DON at the time was notified Resident #5 could not be located.

Record review of the facility's Provider Investigation Report (PIR) dated 5/9/2024 for Intake ID 501268 revealed Resident #4 and Resident #5 had eloped from the facility on 4/30/2024 sometime before the dinner service. The PIR documented a CNA had searched the memory care unit for the residents and was unable to locate them prior to dinner service. Per the PIR, the CNA informed the nurse the residents were missing. The PIR revealed that at 6:38 PM the residents were located, returned to the facility, assessed, and no injuries were identified. The PIR revealed the facility placed plastic covers over the door release buttons throughout the facility and no further elopements had occurred after that time.

Interview on 8/9/2024 at 2:14 PM with the Admin, who said her expectations for a resident elopement were that staff would complete an internal and external search of the facility and call a code orange. The Admin said she expected that staff would search further from the facility to the major thoroughfare approximately a half mile away. The Admin said she expected that when staff heard a door alarm sound the staff would immediately go to the door, visually assess the outdoor area near the door, ensure no one exited the facility, inform the charge nurse, and the charge nurse would complete a headcount. The Admin said during a power outage, all staff were required to go to a specific door until the power returned or the backup generator provided power to the doors, and they were manually reset. The Admin said the plastic covers were installed over the emergency door release buttons near the two nurses' station after the incidents in April, the emergency door release button cover had been installed on the emergency door release in the memory care unit prior to her onboarding, the facility had one reset button for all the doors near the nurse's station on the skilled nursing side of the building and would be installing another one near the nurses' station on the long term care side so staff could reset from each side of the facility.

Record review of Resident #5's elopement risk assessment dated [DATE] revealed she was an elopement risk.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #5's elopement risk assessment dated [DATE] revealed she was an elopement risk. Observation on 7/5/2024 at 2:36 PM revealed Resident #5 was in the activity room with other residents and engaged. Observation on 8/9/2024 revealed Resident #5 was walking in the hall. Resident #5 appeared dressed and appropriately groomed. Observation on 7/5/2024 at 12:49 PM revealed a doorbell had to be pressed to enter the facility. The door was locked and there was keypad near the door to open it. A sign was on the door with a telephone number to call if no one answered the door. Observation on 7/5/2024 at 1:19 PM revealed the exterior doors on the 300 and 600 halls were locked and unable to be opened without using the push bar. The doors had a keypad near them to allow exit. Both doors had a sign that said an alarm would sound if they were opened without the code. Observation on 7/5/2024 at 1:24 revealed the door to the interior courtyard was unlocked and able to be opened. The courtyard was surrounded on all sides by the facility. There were three exits to the courtyard from the facility, but no exit to the exterior of the facility. Video cameras were observed on the courtyard. There was no manner to exit the courtyard to the exterior of the facility. Observation on 7/5/2024 at 1:26 PM revealed the memory care unit was secured with a keypad to enter and exit. On the memory care unit were two CNA's, a nurse, and a hospitality aid. There was an emergency exit at the end of the memory care unit hall, but the door was locked and unable to be opened. The door had a push bar and an alarm if opened. Interview on 7/5/2024 at 2:02 PM with the DON, who said the facility did not have a policy specific to rounding. The DON said the facility's elopement risk residents were on the secure unit. (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 7/5/2024 at 4:08 PM with CNA A, who said she had been employed for three years. CNA A said her primary duties as a CNA were to ensure the residents were groomed, showered, and provided with incontinence care, making the beds, and supervising the residents. CNA A said she completed her rounds hourly most times, but at least every two hours. CNA A said there was no specific policy related to rounds, but the expected practice was to complete rounds at least every two hours. CNA A said when she completed rounds, she checked the residents to determine if they required incontinence care, looked to make sure no residents had fallen, and made sure all the residents were on the hall. CNA A said the staff were required to complete a headcount every fifteen minutes on the secure unit. CNA A said after completing the head count, the staff had to sign that it was completed. CNA A said the DON kept the documentation for the headcounts. CNA A said the facility had completed the headcounts since she had been employed. CNA A said she was not present when Resident #4 eloped on 4/5/2024, when Resident #4 and Resident #5 eloped on 4/30/2024. CNA A said the residents may have eloped through the door from the memory care unit to the rest of the facility if it was not closed completely, but she did not know for sure as she was not at the facility for any of those elopements. CNA A said if a resident eloped the staff were trained to inform the nurse immediately and then begin searching for the resident. CNA A said she did not recall the most recent date the facility provided in-service training related to elopement risk of residents. CNA A the staff were to redirect or distract Resident #4 and Resident #5 if they were near the door to the memory care unit. CNA A said she did not know of any other elopements between 4/1/2024 and 7/5/2024. CNA A said she was required to provide written statements for incidents at the facility including elopements, falls, and other injuries. CNA A said she had never been asked to provide a false statement for any incident by the facility. CNA A said the facility was well prepared to mitigate elopement behaviors on the memory care unit as the door was locked and there were three staff for the unit. CNA A said there were two CNA's and one hospitality staff assigned to the unit daily. Interview on 7/5/2024 at 4:22 PM with RN B, who said that was her first shift on the memory care unit and she had been employed by the facility for one week. RN B said CNA's were expected to complete rounds at least every two hours, and more often when needed. RN B said the CNA's were expected to ensure the residents did not require incontinence care, were present, and not walking into other residents' rooms. RN B said the CNA's were expected to be out on the floor with the residents as often as was possible. RN B said if a resident was identified as missing, the staff were to look through the hall, in the resident rooms, the closets, and the restrooms. RN B said if the resident could not be located on the hall, the staff throughout the facility would begin searching for the resident, staff would begin searching the grounds of the facility, the DON and law enforcement would be notified, and staff would begin searching the areas near the facility both on foot and in cars. RN B said since she had been at the facility there had not been any elopements she was aware of. RN B said nurses also completed their rounds every two hours and ensured all residents were accounted for. (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 7/5/2024 at 4:40 PM with RN C, who said she had worked at the facility for six years. RN C said her primary duties included acting as the charge nurse, ensuring all residents were rounded on, ensuring the CNA's knew the plan of care for the residents, charting, administering medications, providing G-tube care and medications, providing the injected medications to all residents, and ensuring all residents at the facility were safe and properly cared for. RN C said the CNA's were expected to round every two hours. RN C said during the CNA rounds, they were expected to ensure the resident's safety, determine if any residents required incontinence care, ensured all residents had water near them, and ensured the residents were accounted for. RN C said if a resident was determined to be missing, CNA's were expected to notify the nurse and the staff would check the hall. RN C said if the resident was not located on the hall, all the staff would look for the resident on all the halls and the grounds of the facility. RN C said because of the alarms on all the doors of the facility, residents should not be able to elope out of the facility, but they may follow a family out when the family left. RN C said the door alarms had not worked in the past. RN C said when the door alarms did not work the staff would conduct fifteen-minute rounds to ensure all residents were accounted for and log the rounds. RN C said the most recent time the doors were not working was after the inclement weather that interrupted electricity in Houston. Interview on 7/5/2024 at 5:11 PM with the DON, who said she had been employed since 6/17/2024, had been employed prior to that time as well, but not been employed by the facility during the month of April 2024. The DON said the steps taken to ensure residents are unable to elope included securing the doors, reinforcing the lock on the gate of the memory care unit's exterior area, and updating the locks on the doors to not disengage with power outages. The DON said there had been no elopements at the facility since her return on 6/17/2024. The DON said Resident #4 and Resident #5 may have exited by following a visitor out of the memory care unit, but she was unsure how those elopements occurred. The DON said the codes to enter the building and the memory care unit have been recently updated to ensure visitors do not know the codes and cannot accidentally allow residents to leave. The DON said she expected CNA's and nurses to round at least every two hours. The DON said she was unsure if staff in the memory care unit completed headcounts every fifteen minutes. The DON said the facility had taken steps to ensure elopements did not occur including monitoring the doors, monitoring when visitors entered and exited the memory care unit, and redirecting residents away from the doors at all times. The DON said some of the memory care unit residents ate in the dining hall with other residents, but at least one CNA and one hospitality aide monitored them when they were not in the memory care unit. (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 7/5/2024 at 5:45 PM with the Admin, who said her primary duties were to manage the overall operation of the facility. The Admin said on 4/5/2024 Resident #4 went to the business in the building behind the facility. The Admin said the secretary for the other business called the facility and a nurse brought Resident #4 back to the facility. The Admin said she was unsure how Resident #4 got out of the facility, but she believed it was by staff or a resident accidentally pressing an emergency door release button on the wall throughout the facility which released all the doors allowing her to elope. The Admin said when one of the emergency release buttons is pressed all the doors in the facility are released. The Admin said Resident #4 was found in the roundabout leading from the facility to a major thoroughfare and by a hospital parking lot. The Admin said Resident #4 often wants to go home but she cannot due to her diagnoses and needs. The Admin said Resident #4 must have been walking quickly to be found at the roundabout. The Admin said she was unsure how long Resident #4 was out of the facility on 4/5/2024. The Admin said 4/5/2024 was Resident #4's first day at the facility. The Admin said after the incident, all residents were assessed for an elopement risk, and Resident #4 was provided with increased supervision. The Admin said on 4/30/2024 Resident #4 and Resident #5 were able to elope from the facility. The Admin said she was unsure how the residents were able to exit through the backdoor of the memory care unit and through the normally locked gate. The Admin said the gate could not be unlocked by a resident. The Admin said the gate may have been unlocked by the lawncare agency contracted with the facility. The Admin said since the incidents on 4/5/2024 and 4/30/2024 the facility had the alarm contractor review the facility's needs and risks. The Admin said the release buttons had a protective cover placed over them to ensure no accidental releases occurred. The Admin said the facility was also installing a reset button to automatically relock any doors opened with the emergency release buttons. The Admin said if the power goes out in the facility the doors automatically release and have to be reset. The Admin said the staff have been provided training to ensure that any time the electricity was to go out the staff immediately check and reset the doors. The Admin said the facility was monitoring the doors weekly to ensure there were no further incidents. The Admin said the facility had also added a third staff to the memory care unit which now consisted of two CNA's, a hospitality aide, and a nurse. The Admin said there had been no other concerns in the memory care unit since that time. (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 8/8/2024 at 11:09 AM with the Maintenance Director, who said he had been employed for four years. The Maintenance Director said his primary duties included overall facility maintenance of any needs and repairs for the facility. The Maintenance Director said the residents had eloped on 4/5/2024 and 4/30/2024 by following staff and/or visitors out of the memory care unit. The Maintenance Director said on 4/05/2024 Resident #4 eloped from the facility through the back door of the memory care unit. The Maintenance Director said the back door may not have been secured when Resident #4 eloped on 4/5/2024 because when the facility's power surges or goes out the doors disengage. The Maintenance Director said when that occurred staff had to reset the doors. The Maintenance Director said when the facility's generator was engaged due to lack of power the doors disengage and the staff have to reset the system. The Maintenance Director said the facility had the same system currently, but staff were provided with an in-service training related to resetting and checking all exit doors in the event of a power outage or surge. The Maintenance Director said the cover over the emergency door release button had been in place in the memory care unit since it was converted from long term care to memory care multiple years ago. The Maintenance Director said the covers over the other two emergency door release buttons were installed in May of 2024. The Maintenance Director said the emergency door release button could have been the cause of the elopements if someone had accidentally pressed the button. The Maintenance Director said he assisted in presenting the in-service trainings. The Maintenance Director said to his knowledge all staff have received the training. The Maintenance Director said he did not know how long the residents were outside the facility on 4/5/2024 or 4/30/2024. The Maintenance Director said he had made adjustments to the doors to increase the speed at which they close and relock if the release bar is pressed. The Maintenance Director said there had been no more elopements since the door adjustments and cover over the emergency door release buttons were installed. Interview on 8/8/2024 at 1:11 PM with LVN D, she said she had been employed since April 2024 and worked primarily on the memory care unit. LVN D said she was not in the building when Residents #4 and #5 eloped on 4/30/2024. LVN D said she was informed that two residents were able to elope. LVN D said since that time the facility had routine meetings and in-service related to resident supervision and elopements. LVN D said the facility had conducted rounds every fifteen minutes on the secure unit until 8/5/2024. LVN D said the staff in the memory care unit completed two security checks on the front and back doors of the unit each shift. LVN D said the staff were alert for any alarm sounds indicating a door on the memory care unit had become unlocked. LVN D said all the facility's staff were trained where to go if the power went out during a shift. LVN D said she was trained that if power went out the facility's doors became unlocked. LVN D said the staff were trained to go to the doors and secure them to ensure residents did not exit, and nurses would conduct a head count to ensure no residents were unaccounted for, and additional staff would monitor the outdoor area of the facility to ensure no residents had left when the power was out. LVN D said since 4/30/2024 no residents had eloped, and the facility was secure at all times. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/09/2024
NAME OF PROVIDER OR SUPPLIER: Villa Toscana at Cypress Woods		STREET ADDRESS, CITY, STATE, ZIP CODE: 15015 Cypress Woods Medical Dr Houston, TX 77014	

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	LVN D said during in-service trainings related to elopement, he was trained that if the power went out or there was a power surge at the facility staff were immediately to go to the doors, nurses were expected to complete a headcount, and staff that reached the doors first were to complete visual inspection of the area around the door to ensure no residents had eloped prior to the staff reaching the doors. LVN D said the staff had to demonstrate their understanding of the information to the DON. LVN D said the doors had an alarm which would chirp if the doors became unlocked. LVN D said if the staff heard a door alarm sound or chirp, the staff were to go to the door immediately, complete a visual assessment of the area around the door to ensure no residents had eloped, and reset the alarm. LVN D said the staff were also expected to attempt to identify any residents or visitors who may have caused the alarm to sound so they could be reeducated on the door alarms. Interview on 8/9/2024 at 1:20 PM with CNA E, who said she had been employed for one year. CNA E said her primary duties included assisting residents with ADL's and everyday care. CNA E said she typically work on all halls, and did not have a specific hall she was assigned to. CNA E said would assist in the memory care unit, but it was not her typical assignment. CNA E said when she worked in the memory care unit she was expected to supervise the residents and ensure they did not get out of the secured doors from the unit. CNA E said she had recently received in-service training related to resident abuse, neglect, and exploitation, and resident elopements. CNA E said during the resident elopement in-service training she was informed that if a door alarm sounded in the facility, all CNA staff went to a door and stood by it until the all clear was called and the system was reset. CNA E said she was also informed that if the power went out at the facility the doors unlocked. CNA E said during the in-service training she was instructed that if there was a power outage at the facility the CNA's were to go to all the doors and gates of the facility until the all clear was sounded and the door locks were reset with the return of power or the backup generator and someone pressed the reset button. CNA E said the nurses completed a headcount while the CNA's remained by the doors. CNA E said if a specific door alarm sounded staff went to that door, went outside the door and conducted a visual assessment of the area around the door to ensure there were no residents outside . CNA E said she was not present when Residents #4 and #5 had eloped in April of 2024, but she was informed it occurred. CNA E said since the residents were able to elope in April of 2024, the facility had installed plastic covers over the emergency door release buttons near the two nurses' stations. CNA E said there had been a cover over the emergency release button in the memory care unit since she had been employed. (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 8/9/2024 at 1:27 PM with LVN F, who said she had been employed for seven years. LVN F said her primary duties included medication administration, monitoring the residents, g-tube care, monitoring residents for any changes of condition, and making notifications of resident needs to the physicians and families. LVN F said she primarily worked on the 200-Hall and 300-Hall. LVN F said she had recent in-service training related to resident abuse, neglect, and exploitation, rounding, and resident elopements. LVN F said during the elopement in-service trainings she was instructed that if a resident was determined to be missing staff were to visually observe all residents, conduct head counts, and check the perimeter of the facility for the resident. LVN F said she was also informed that if the facility lost power for any reason the doors unlocked. LVN F said during the in-service training staff were informed that the CNA's were each assigned to a specific door to ensure no residents could elope. LVN F said another staff was assigned to press the reset button to reset the doors when the power was restored or if the backup generator was providing power. LVN F said she was trained that if the facility's power flickered staff must check each door and ensure no residents had eloped. LVN F said the staff were to complete a visual assessment outside the door to ensure there were no residents outside. LVN F said if staff heard a door alarm sound, the staff were instructed to assess the exterior near the door, complete a headcount, and monitor the door until it was reset. LVN F said if staff could not locate a resident the staff called a code orange. LVN F said the nurses completed a head count, the CNA's searched each room, restroom, closet, shower room, or other area accessible to residents, and additional staff searched the exterior of the facility to a perimeter of approximately one mile. Interview on 8/9/2024 at 1:36 PM with CNA G, who said she had been employed for one year. CNA [TRUNCATED]