STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676279	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crown Point Health Suites	6640 Iola Avenue Lubbock, TX 79424

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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** 43344 Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 5 residents (Resident #1) reviewed for elopement. The facility failed to ensure Resident #1 who was exit seeking on the night of 04/14/25 around 11:00 PM and the morning of 04/15/25 before 8 AM and then eloped (via motorized w/c) from the facility to a local church (. 17 miles) the afternoon of 04/15/25 at 2:20 PM. Staff were unaware of Resident #1's elopements when the facility was notified by a Community Member via telephone on 04/15/25 at 2:39 PM that the resident was at a church. An Immediate Jeopardy (IJ) was identified on 5/08/25 at 4:53 PM. The IJ template was provided to the facility on [DATE] at 6:38 PM and approved on 05/09/25 at 9:55 AM. While the IJ was removed on 05/08/25 at 11:48 AM, the facility remained out of compliance at a at a scope of no actual harm and a severity of a potential for more than minimal harm that was not immediate jeopardy because all staff had not been trained on 05/9/09. This failure could place residents at risk for injuries due to not receiving the appropriate level of supervision. Findings included: Record review of Resident #1's face sheet, dated 04/24/25, revealed an [AGE] year-old-male was admitted to the facility on [DATE] with diagnoses to include Parkinsonism (a central nervous system disease), UTI (Urinary Tract Infection), and cognitive communication deficit (communication deficit). Record review of Resident #1's Comprehensive MDS dated [DATE], revealed the following: Section B Hearing, Speech, and Vision. Resident #1 had adequate hearing, no hearing aide, clear speech, easily understood, understands others, adequate vision and wore no corrective lenses. Section C Brief Interview for Mental Status score revealed a score of 08, which indicated the resident's cognition was moderately impaired. (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	Section E Behavior No presence of Wandering Section I Active Diagnoses 12300. Urinary Tract Infections (UTI) (Last 30 days) 15300. Parkinson's Disease Section V Care Area Assessment (CAA) Summary: CAA Results: (List the CAA that triggered and not Care Planned) 06. Urinary Incontinence Section N Medications N0410. Medication Received F. Antibiotic coded 7 days. Record review of Resident #1's care plan, dated 04/07/25, revealed the following: Resident #1 was a long-term guest at the facility with a primary dx of Parkinson. Resident #1 had a goal to attain and or maintain maximum self- performance in ADLs. (initiated 11/17/21). Resident #1 was an elopement risk/wanderer as evidence by Resident #1 had a history of leaving the facility unattended in his electric scooter. Resident #1 had a goal to not leave the facility unattended and to have his safety and security protected. The following interventions implemented: Assess for falls, distract Resident #1 from wandering by offering pleasant diversions, identify pattern of wandering, and removal of the electric scooter until he is safe to use the motorized scooter . (Initiated 04/16/25) Record review of Resident #1's physician orders dated 04/24/25, revealed the following: Cephalexin (antibiotic) 500 MG (Take 1 tablet every 6 hours for 7 days) for Dx UTI; Order date 04/12/25. Morphine Sulfate oral solution 100 mg;(.25 ml buccally (cheek/mouth); .5 buccally every hour; .75 ml buccally; 1 ml buccally every hour) order date 3/28/25 Record review of the MAR , 04/24/25, for Resident #1 revealed, the following medications: Cephalexin 500 MG every 6 hours related to urinary tract infection (Start date 04/12- End date 04/19/25). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Entacapone 200 MG 4 times a day related to Parkinson's disease (Start date 04/01- End date 04/24/25. Morphine Sulfate (Concentrate) Oral Solution 100 MG/5ML every hour related to moderate pain. (pain level 4) Record review of Resident #1's assessment dated [DATE] revealed: There were no witnesses to the incident (elopement). Immediate Action taken: Resident #1 given water, full body assessment, 0 injuries. Mental Status: Oriented to person. Predisposing Physiological Factors: Impaired Memory and Current UTI. Predisposing Situation Factors: Using Wheelchair. Record review of lab results, dated 04/15/25, revealed: Resident #1's urine sample was collected and received on 04/11/25. Resident #1's urine sample was verified on 04/15/25. Resubmission of labs to the doctor made on 04/15/25 and recommendation of continue oral antibiotics and ad Rocephin for 3 days. (Handwritten on the same document) Record review of Resident #1's progress notes, dated 01/23/25-04/24/25, revealed: LVN F documented on 04/15/25 at 5:50 AM: Resident #1 was noted to be on his knees and holding on to chair in his room. assisted Resident #1 up from floor and onto recliner with x2 staff, Resident #1 confused and requesting his shoes to go look for his keys, attempted to redirect guest (Resident #1) to time and place, contacted Family Member G via Resident #1's personal phone, Family Member G requested morphine to be administered as he may be in pain. Resident #1 continued to ask to get in electric wheelchair, guest (Resident #1) was then assisted with transferring to w/c, d/t guest (Resident #1) attempting to get out of recliner without assistance. pain medication administered per request, Resident #1compliant with taking medication. guest (Resident #1) then attempted to leave facility stating he needed to go lock his truck d/t confusion. The MDS Coordinator was then contacted to come talk to Resident #1 and sit with him. After visiting with family and speaking to them Resident #1 then agreed to lay down assistance. Provided with transfer, call light placed within reach and reminded Resident #1 to call for assistance, The MDS remained in room until guest (Resident #1) fell asleep. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	LVN D documented on 04/15/25 at 2:54 PM: This nurse sitting at nurse's station when she was informed by ADON and MDS Coordinator came by and advised me that front desk clerk received a phone call from a church down the street from facility stating that this resident (Resident #1) was there, staff went to get resident and help him back to facility. This nurse assessed guest (Resident #1) after return, guest (Resident #1) tired and sleepy, redness to face, temp 98.8 at this time, no injuries noted, denied any pains or problems at this time and resident went to sleep after being placed in bed. Doctor notified and no new orders given. The ADON documented as a late entry on 04/15/25 at 3:00 PM: At 3:39 PM this nurse notified by receptionist that the Community Member called to notify Resident #1 was at their church. I (ADON) and MDS Coordinator drove in private vehicle to the church, Resident #1 inside church with Community Member, noted to be alert and talkative, answering questions appropriately, no sx of distress or injury noted, facility van arrived, and guest (Resident #1) loaded into w/c van on motorized w/c and driven to facility, Resident #1 in building at 2:55 PM. This nurse (ADON) and CNA (unidentified) assisted Resident #1 to bed. During an interview on 04/24/25 at 2:20 PM, Resident #1 could not recall the incident when he left the facility unauthorized and went to church on 04/15/25. He stated he had not been to a church. He said staff treated him well. He did not have any concerns. An observation on 04/24/25 at 2:20 PM revealed Resident #1 in the bed, well groomed. During an interview on 4/24/25 at 9:30 AM, the MDS Coordinator stated she was also a family member of Resident #1. She stated regarding Resident #1's elopement that occurred on 04/15/25, Resident #1 was alert, and they were surprised he left the facility. She said Resident #1 had never eloped or left the facility premises before. She said once the Community Member notified the facility, she was immediately notified, and staff and she went to retrieve him from the local church. The MDS Coordinator stated Resident #1 could tell the Community Member a Family Member G's phone number but was off by one number. She stated Resident #1 had no injuries and had not tried to leave since 04/15/25. She stated Resident #1 did not remember the incident. She stated as an employee and a family member she did not have any concerns with how the facility staff responded to Resident #1 eloping from the facility. She stated she had worked with Resident #1 in the facility for 5 years, and Resident #1 had never tried to exit the facility. She stated he had not indicated that he would leave the facility. MDS coordinator stated Resident #1 would go outside of the facility unsupervised and never left. The MDS Coordinator explained the facility was not locked and residents had the freedom to go in and out of the facility. She stated she and Family Member G was surprised that Resident #1 left the facility premises. The MDS Coordinator stated as a result of the incident Resident #1 was assessed and as MPOA she and Family Member G decided that Resident #1 could not operate the motorized wheelchair safely , but this would be reassessed at a later date. She said he was given a manual wheelchair and appeared to be doing well with the transition. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/24/25 at 10:15 AM, CNA B stated Resident #1 attempted to leave the facility the morning of 04/15/25. She stated she and CNA C worked together on the morning of 04/15/25. Resident #1 told her he wanted to go out the door (door specification was not made during the interview). She stated Resident #1 expressed that he wanted to see his girlfriend. CNA B stated she offered to give Resident #1 coffee to distract him. She stated she started walking to the dining room area with her back to Resident #1 and thought Resident #1 was behind her but looked, and Resident #1 was not. She stated she observed Resident #1 leaving out the (unspecified at the time of the interview) door. She said she called for CNA C to help get Resident #1 back in the facility. She said they could get Resident #1 back in the facility by telling him it was cool outside. She said he came in and gave him a coffee and a newspaper. She reported that Resident #1 attempted to exit the facility to LVN D, LVN E, and the ADON. She stated Resident #1 tried to leave the facility before 8:00 AM. She could not remember the response from LVN D, E, and the ADON but was almost sure the ADON and LVN D told her to keep an eye on Resident #1, but she was unsure. CNA B stated she went to lunch and observed staff in the parking lot when she returned. She stated she was a few minutes late from lunch, so she observed staff in the parking lot around 2:30 PM. She stated LVN E told her that Resident #1 had left the facility premises. She stated she observed Resident #1 after he returned to the facility, and Resident #1 did not have any injuries. She stated she could not remember when she went to lunch but remembered seeing Resident #1 in his room before leaving for lunch. She stated before 04/15/25, Resident #1 had never tried to leave the facility during her shift. During an interview on 4/24/25 at 10:38 AM, LVN E stated before Resident #1 eloped on 04/15/25, he was diagnosed with a UTI. She stated his behavior was different. She stated he was going extremely fast in his motorized wheelchair. She stated the staff would try to redirect him to slow down, but he did not respond. She stated this was abnormal for Resident #1. She stated she had also heard he had been crawling on the floor (on an unknown date and time), which was abnormal for Resident #1. LVN E stated she was told by LVN F that Resident #1 attempted to get out of the facility the previous night (04/14/25) through the back door. She stated LVN F stated Resident #1 kept going to the back door and the staff had to redirect Resident #1. She stated no other staff reported to her that Resident #1 attempted to get out of the facility at any other time. She stated she was unsure but believed Resident #1 had a UTI, but the results had not returned on the night of 04/14/25. LVN E stated Resident #1 had never tried to leave the facility and typically was calm. She stated she had never observed him try to leave before the day of the incident on 04/15/25 and since the incident on 04/15/25. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/24/25 at 10:51 AM, LVN D stated Resident #1 had been sick with the diagnosis of a UTI. She stated on 04/15/25, Resident #1 was awakened by activity staff, around 2:05 PM, Resident #1 said bye to staff and grabbed a newspaper. LVN D stated she believed this was when he went out the main door from his facility wing. She stated she did not see him go out the door personally but did observe the camera footage. She stated Resident #1 was on his way to play dominoes as he does daily and must have become confused on his way to the activity. She stated it was only a few minutes later when she received a call from the ADON stating Resident #1 was not in the facility. LVN D stated the last time she observed the resident was around 2:00 PM because she knew he was going to the dominoes in activities, and she had given him an oxygen tank. LVN D stated she did not observe Resident #1 leave the facility, but once they were notified, he exited and he returned, she assessed Resident #1. LVN D stated Resident #1 had no injuries and appeared to know he had left and should not have. LVN D stated he was flushed red in the face and seemed disappointed in himself for leaving . LVN D stated she was aware the night before Resident #1 attempted to leave the facility on the night shift. LVN D stated LVN F reported that the MDS Coordinator had been called to calm him down. LVN D stated LVN F reported to her during shift change that on the night of 04/14/25, Resident #1 was confused and attempted to search for his girlfriend and truck outside. LVN D stated it was not abnormal for Resident #1 to go outside in his motorized wheel chair but he would not leave the premises. LVN D stated she remembered CNA B reporting Resident #1had attempted to leave but was unaware that it was a separate incident from the night of 04/14/25, which LVN F had already reported to her. She stated she thought CNA B was confusing incidents and was unaware that she was reporting a new and separate incident. LVN D stated Resident #1 had never tried to leave since his successful attempt on 04/15/25 . She stated Resident #1 had never exhibited the behavior of leaving the facility before 04/15/25 and before the report she received from LVN F. She stated Resident #1 had received the dx of the UTI at least 2 days before his successful elopement. She stated Resident #1 behavior had changed since his UTI because he was talking about his truck (which was no longer at the facility), his ex-girlfriend, and his time during the war. LVN D stated he (Resident #1) was adamant about searching for his ex-girlfriend before his successful elopement. She said Resident #1 kept asking about his ex-girlfriend thus the reason she described it at adamant. LVN D stated she had never heard him talk about his ex-girlfriend. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/24/25 at 11:11 AM, the ADON stated Resident #1's cognitive level had been decreasing, but his leaving the facility premises was something that had never happened before. ADON stated Resident #1 does get UTIs frequently. ADON stated when Resident #1 had a UTI, he was confused but not typically disoriented. ADON stated Resident #1 does not usually exit seek. She stated Resident #1 had a motorized wheelchair, enabling him to leave the facility. She stated he then had a manual wheelchair that he could ambulate throughout the facility but not as quickly, nor can he use the door's momentum to open doors outside the facility. She stated the week that he successfully got out of the facility, they knew he had a UTI because of the behaviors that he was exhibiting. She stated he had awakened the night before, was confused, thought his RV was outside, and had climbed out of bed. She stated because of the behavior change, they had Resident #1 checked, and he was positive for a UTI. She stated Resident #1 thought his RV was outside on 04/14/25. She stated Family Member G was called but because he did not live near the MDS Coordinator was called and she came to assist Resident #1 and calm him down. She stated the MDS Coordinator came and stayed the remainder of the night . She stated she believed Family Member H came after the MDS Coordinator but was unsure what time she left. She stated additional instruction for medication because of the increased behaviors. She stated on 04/15/25, Resident #1 was not exhibiting any behaviors and had not exhibited any behaviors that he wanted to leave the facility. The ADON stated she had not received any reports that Resident #1 attempted to leave on the morning of 04/15/25. She stated if she knew that he had tried to leave the facility the morning of 04/15/25, she would have placed him on 1:1. ADON stated if he was voicing that he wanted to leave and go to the door, she would consider that exit-seeking behavior. She stated Resident #1 had no history of exit-seeking behavior. She stated the day he eloped and was returned, he was assessed, and there were no injuries. ADON stated the resident had only been gone 8-13 minutes. ADON stated she observed on the camera that Resident #1 barreled through the exit door from the wing in which he resided. ADON stated she did not see anyone assist him through the door. ADON stated once he returned to the facility, he switched out his motorized wheelchair for a manual wheelchair , assessed him, and increased monitoring for him. During an interview on 4/24/25 at 11:40 AM, CNA I stated she did not know what happened the day Resident #1 eloped but that she worked with him the night before. CNA I stated she left the night before at midnight, but that Resident #1 was not in a good mood. CNA I stated he was not very happy and he was doing different things. CNA I stated Resident #1 was adamant that he wanted to leave and kept going for the doors. She stated she and her coworker would offer him snacks and try to redirect him so that he would get his mind off of wanting to leave. CNA I stated Resident #1 said he needed to go home and needed to get something out of his truck. She stated she could not remember who worked with her that night but that she, the other CNA (unknown identity), and the nurse (LVN F) on duty knew he wanted to leave. CNA I stated the nurse did not say much but stated that Resident #1 sometimes would get in those moods. She stated she had never observed Resident #1 act in that manner. CNA I stated on 04/14/25, that was the first day she had observed him exit seek, and speak about his truck and wanting to go home. CNA I stated she was unaware if anyone came to sit with him that night (04/14/2025). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 04/24/25 at 12:09 PM, Family Member G stated he had no concerns with how they handled Resident #1's elopement. Family Member G stated Resident #1 liked to sit on the porch and had never left the premises, and his leaving was unexpected. Family Member G stated he knew that Resident #1 had a UTI and they were treating it. Family Member G stated he was called the night of 04/14/25 because Resident #1 was anxious and wanted to go out to see his RV. Family Member G stated the MDS Coordinator stayed with him until Resident #1 slept. Family Member G stated he removed his motorized wheelchair, especially until he started to feel better but that he had an alternative wheelchair to get around in. During an interview on 04/24/25 at 12:10 PM, Family Member H stated on the night of 04/15/25, she stayed the entire night with him. Resident #1 was confused, but she could see that his antibiotics were working because he became okay. Family Member H stated she had no concerns with how the facility handled Resident #1's elopement. Family Member H stated it was unexpected and he has always had free [NAME] in the facility. Family Member H stated Resident #1 normally knows what he is doing and does not require supervision from staff. Family Member H stated everyone was caught off guard. She stated Resident #1 would go and sit on the porch and visit with his military friends and had never left the facility. Family Member H stated no one expected him to leave. Family Member H stated in the past Resident #1 had a girlfriend that stayed in the RV that was kept on the premises . Family Member H stated Resident #1 may have become confused. An observation was made on 04/24/25 at 2:00 PM with the accompany of CNA B of the service door (unlocked) that CNA B and CNA C reported Resident #1 exited the morning of 04/15/25. Observed a blue and white sign that read Notice employees only beyond this point. The door (unlocked) lead to a short hallway and an additional door (unlocked) that lead to the outside of the facility. During an interview on 4/24/25 at 2:30 PM, CNA C stated she does not usually work in the area where Resident #1 resides in the facility. CNA C stated she did not know the staff names very well, but before 8:00 AM on 04/15/25, Resident #1 was able to get out of the facility through the side door where the employees come in and out. CNA C stated she and the other staff ran after him. CNA C stated when they brought him in, he said, This was not the dining room. She stated she could not recall if he stated he wanted to leave. CNA C stated she did not report this to the nurse because she believed when he got out there was a nurse out there coming in. CNA C stated she thought the other staff told the nurse but did not observe this. CNA C stated she did not observe Resident #1 leave the facility but was later told he left and was at the local nearby church. CNA C stated Resident #1 did not exhibit any exit-seeking behaviors, nor did he express that he wanted to leave before he successfully eloped from the facility (on 04/15/2025). During an interview on 04/24/25 at 2:38 PM, the MDS Coordinator said she did come to the facility on [DATE] to assist in calming Resident #1 down. MDS Coordinator stated she sat with him for an hour and a half. She confirmed Family Member H stayed with Resident #1 the following night. MDS Coordinator stated Resident #1 once had an RV on his ex-girlfriend's premises. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/24/25 at 2:53 PM, the DON stated she was unaware Resident #1 had eloped until the front desk clerk called her and told her he was at the local nearby church. DON stated they immediately took the van and went to pick Resident #1 up. DON stated they (staff) assessed Resident #1, and there were no injuries. DON stated Resident #1 could state his name at the time of the incident. She stated Resident #1 had never done this (left the facility premises) before. She stated Resident #1 had bladder cancer and had a history of UTIs. DON stated when he had a UTI, he experienced confusion. She stated she knew he was confused and talked about his ex-girlfriend the night before. DON stated he had not spoken to his ex-girlfriend in about 3 years. She stated it was her understanding that the MDS Coordinator, who was also related to Resident #1, stayed with him, oriented him to place and time, and then left. DON stated Resident #1 was on antibiotics for the UTI and received an additional dose of Rocephin after he successfully got out of the facility on 04/15/25. She stated Resident #1 had never been exit-seeking. She stated she was unaware that Resident #1 was attempting to leave the facility on the night of 04/15/25. DON stated she was aware that the MDS Coordinator took him outside to show him that his RV was not outside. DON stated she was unaware that Resident #1 attempted to leave the facility on the morning of 04/15/25. The DON stated she had spoken with staff, specifically the nurses, and no one had reported this to her. She stated they were aware since he had the UTI, he had increased confusion but no exit-seeking behaviors. She stated it is common for him to be forgetful and have confusion. She stated that if a resident was exhibiting behaviors or signs of elopement or wanting to leave, the staff should report the behavior immediately to their chain of command. She stated the resident would be placed 1:1 at that time but that the facility was not a locked unit. She stated she had been at the facility for [AGE] years, and in all of her years at the facility, a resident had never eloped from the facility because they take elopement seriously. She stated if she had been made aware, they would have attempted to get a family member or a staff to monitor Resident #1. She stated she did not personally speak with LVN F. She stated outside of the attempt to leave, she was unaware that the elopement was not preventable, and they addressed the elopement according to policy. She stated that they were aware that he was experiencing confusion, redirecting as needed, and that he had a UTI and was actively addressing the diagnosis. She stated before the elopement, they had no issue with Resident #1 going outside and moving throughout the facility unsupervised. She stated Resident #1 using the service door would have indicated that something was off because residents do not use that door. She stated the purpose of increased supervision was to promote safety and ensure the residents needs were met. She stated she was familiar with the facility's policy regarding preventing incidents and accidents and resident supervision. She stated the potential negative outcome was Resident #1 could have gotten too hot or could have been in danger. She stated the system to monitor behavior change and the need for increased supervision was to communicate with the physician, get orders if needed, and increase supervision. She stated she had been trained on increasing resident supervision. She stated she expected her staff to report any changes or exit-seeking behavior, pleasantly reorient the resident, and get the team involved. DON stated there was no increased supervision after the exit seeking behaviors on the night of 04/14/25 and the attempted exit on 04/15/25 because it was not communicated that Resident #1 tried to leave on either occasion and the second was not reported at all. DON stated the charge nurse, ADON, DON or ADM could implement increased supervision . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676279	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crown Point Health Suites	6640 Iola Avenue Lubbock, TX 79424

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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	During an interview on 4/24/25 at 3:18 PM, the ADM stated on 04/14/25, the MDS Coordinator had come to the facility to assist in calming Resident #1 down. The ADM reported that Resident #1 was agitated on the night of 04/14/25. ADM stated Resident #1 was not described as an elopement risk or exit seeking. ADM stated she did not speak with LVN F. ADM stated before Resident #1 eloped on 04/15/25, he had not exhibited any signs that he would elope. ADM stated she was unaware that he was actively trying to exit seek the night before on 04/1425 and that he attempted to leave out of the service door the morning of 4/15/25. ADM stated she expected staff to report to their chain of command immediately. ADM stated they were not a locked facility, and if she had been made aware, they would have selected a staff if they had one or contacted the family to sit with him. She stated they did not have any indication that he would leave. She stated the resident had a history of going outside and being around the facility without supervision and never had left the premises. She stated if he had a history of this behavior, interventions would have been put in place. She stated the purpose of increased and adequate supervision was the general disposition of the resident and to allow time to see what the situation was for the identified resident, like in the case of Resident #1. ADM stated she was familiar with the facility policy, which prevents incidents and accidents and provides adequate supervision. She stated specifically Resident #1 was at risk of being harmed . ADM stated the system to monitor was if the resident acted outside their baseline or desired to leave, they should increase supervision. She stated that the family would cover the 1:1 supervision if they did not have staff. She stated she had been trained on increased supervision. The ADM stated for the staff to communicate to their chain of command. She stated increased supervision did not occur because it was not communicated that he was exit seeking on 04/14/25 or 04/14/25. She stated the charge nurse or even the on-call person could implement increased supervision . She stated the cameras were not working and unable to show any footage from the day of the event. During an interview on 04/24/25 at 3:30 PM, LVN F stated she was the charge nurse on the night of 3/14/25. She stated that Resident #1 had gotten out of bed, and LVN F said he needed to go outside because his RV was outside. LVN F stated he was agitated, so from Resident #1's phone, they called Family Member G. LVN F stated this did not calm him down, so they placed him in his recliner. Since he was still restless, they put him in his motorized wheelchair. LVN F stated before placing him in the wheelchair chair, they gave him morphine to help him calm down at the request of Family Member G. LVN F stated Resident #1 kept talking about his ex-girlfriend and that he needed to go outside. LVN F said they offered him coffee, but he was still adamant about going outside to check his RV. LVN F stated she sat in front of the door, attempting to redirect him. She stated she called the ADON, who instructed her to call the MDS Coordinator. She stated the ADON ultimately called the MDS Coordinator, and she (The MDS Coordinator) came to the facility and stayed with Resident #1 until he fell asleep. LVN F stated his agitation happened between midnight and 1:30 AM. She stated that Resident #1 was not oriented to time and place because he indicated the MDS Coordinator lived over 300 miles away. She stated she did pass Resident #1's behaviors in a report (shift change) on the morning of 04/15/25 to LVN D and LVN E. LVN F stated she did not see Resident #1 on the morning of 04/15/25. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 04/25/25 at 10:36 AM, the Community Member stated on 04/15/25 around 3:30 PM that he was outside looking for another person. He stated he was unsure if 3:30 PM was the exact time. He stated he saw Resident #1 in his motorized wheelchair, rolling as if he had a purpose. The Community Member spoke to Resident #1, and he did not speak. He stated Resident #1 rolled to one of the church's doors, and when he asked him where he was going, Resident #1 stated he needed to get inside the church. When the Community Member asked why, he stated he needed to fly. The Community Member stated he made a joke about he could not fly in the facility. The stated when Resident #1 did not respond to humor, that was when he thought maybe Resident #1 was from the facility across the street. The Community Member stated Resident #1 could tell him his name and gave him a number that did not work. The Community Member stated when he called the facility and gave them Resident #1's name, the person on the other end of the phone stated, Thank you so much. We have been looking for him. The Community Member stated less than 5 minutes the facility staff was there with a facility van. He stated Resident #1 looked very well taken care of. He stated Resident #1 was with him for no more than 10 minutes. The Community Member stated he had been a community member for a long time and had never experienced a resident eloping from the facility. Record review of the facility policy, Wandering and Elopements, dated March 2019, revealed: Policy Statement The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If an employee observes a resident leaving the premises, he/she should: a. attempt to prevent the resident from leaving in a courteous manner; b. get help from other staff members in the immediate vicinity, if necessary; and c. instruct another staff member to inform the charge nurse or director of nursing services that a resident is attempting to leave or has left the premises. Record review of the facility's policy, Safety and Supervision of Residents, dated July 2017, revealed: Policy Statement Our facility striv [TRUNCATED]