| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 000 | INITIAL COMMENTS<br><br>The State Agency (SA) conducted two (2) Complaint Investigations (CI MS #25238 and CI MS #25334) at the facility on 06/03/24 through 06/04/24. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. The SA investigated CI MS #25238 for accidents and hazards and cited F689. The SA investigated CI MS #25334 for alleged abuse and no deficiencies were cited.<br><br>At the time of the survey the facility had a census of 52 and they were licensed for 55 beds. | F 000 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff and resident interviews, record review, and facility policy review the facility failed to immediately notify administrative staff and the local police department to ensure the immediate safety of a cognitively intact resident who left the facility parking lot on foot when he returned after being out on pass with a friend for one (1) of three (3) residents reviewed. Resident #1.<br><br>Findings included: | F 689 | F689 FREE OF ACCIDENTS HAZARDS/SUPERVISION/DEVICES<br><br>I. On May 25, 2024, Resident #1 was assessed by emergency personnel upon arrival to location of resident. Resident #1 was transported by emergency personnel in ambulance to local hospital and admitted on May 25, 2024. On May 28, 2024, Resident #1 was discharged from local hospital and returned to facility. | 7/5/24 |

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

Electronically Signed | 06/18/2024

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| F 689 | Continued From page 1<br>Record review of the facility policy, "Incidents and Accidents Investigating and Reporting" with revised date of 05/25/24 revealed "Policy: It is the policy of this facility for staff to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident ...Compliance Guidelines: 1...It is the responsibility of the department supervisor to notify the Administrator or Director of Nursing Immediately..."<br><br>Record review of the facility policy, "Missing Resident/Elopements "updated 2/3/2023 revealed " ...Procedure: 1. It is the responsibility of all personnel to report any resident attempting to leave the premises or suspected of being missing to the Charge Nurse as soon as practical. 2. Should an employee observe a resident leaving the premises, he/she should: a. Attempt to prevent the departure...4. Should an employee discover that a resident is missing from the facility, he/she should:..c. Notify the Administrator and the Director of Nursing Services;...Notify law enforcement officials; ..."<br><br>Record review of the "Incident Report" from the Police Department revealed that on 05/25/24 at 0745, Officer (Proper Name) was dispatched to (Proper Name) Nursing Home in reference to a missing resident ...At approximately 13:00 (1 PM), the officer was dispatched to an area in reference to a male laying down on the ground. Once he arrived on scene, he made contact with the male that was sitting on the ground. The officer introduced himself and asked him what his name was. Resident #1 gave the officer his proper name. The Officer then called the Administrator to report that Resident #1 had been | F 689 | Upon immediate return, Resident #1 was placed on one-on-one observation twenty-four hours a day indefinitely to ensure safety and well-being of Resident #1. Resident #1 was deemed to be at risk for elopement on April 29, 2024, per wandering risk assessment and wander guard was placed. On May 25, 2024, wander guard was in place upon arrival to location of resident.<br><br>On May 25, 2024, Nursing Supervisor resigned effective immediately. On May 26, 2024, Charge Nurse was provided one on one education on elopement protocols by Assistant Director of Nursing. On May 27, 2024, Licensed Practice Nurse #1 resigned effective immediately.<br><br>II. All residents in the facility as identified at risk for elopement in the electronic health record computer system have the potential to be affected by this alleged deficient practice.<br><br>III. On May 25, 2024, 100% resident census checked to ensure all residents were present and accounted for in facility by Registered Nurse. Inservice initiated with facility staff on May 25, 2024, on Abuse and Neglect Policy by Assistant Director of Nursing. On May 25, 2024, Abuse and Neglect Policy reviewed and revised by Director of Operations. Inservice initiated with facility staff on May 26, 2024, on updated Abuse and Neglect Policy by Assistant Director of Nursing. | |

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located, and she and three nurses arrived on scene to check on Resident #1.

On 06/03/24 at 9:40 AM, an interview with Administrator (ADM) revealed that on 05/25/24 at 7:32 AM, the Director of Nursing (DON) called her and reported that Nursing Supervisor had called her and reported that Resident #1 had left walking from the facility the night before when his friend brought him back just before midnight. The ADM revealed that during their investigation, they found out that the Charge Nurse called the Nursing Supervisor to see how they needed to handle the situation since Resident #1 was in his right mind and able to make his own decisions. The ADM revealed that Nursing Supervisor informed them to put a note in the computer since Resident #1 was still out on leave and to just let him go. The ADM revealed that the Nursing Supervisor was packing her stuff up the next morning because she knew she had messed up. The ADM revealed that the Nursing Supervisor should have reported this to the DON or Administrator and called 911 to ensure that Resident #1 was safe. The ADM revealed when she heard about this situation, she called 911 and the police were at the facility when she arrived on 05/25/24. She revealed that they split everyone up in pairs and sent them out in different directions to search roads, ditches, bridges, businesses, neighborhoods, wooded areas, and local restaurants for Resident #1. The ADM revealed that the police department called her and reported that they found him on 05/25/24 at 1:00 PM about a mile from the facility. The ADM revealed that she drove to the site and found Resident #1 sitting in the back of the police car. An ambulance arrived and they transported him to the local hospital to be checked out. The ADM

Inservice initiated with facility staff on May 25, 2024, on Elopement, Wandering, and Reporting by Assistant Director of Nursing. On May 25, 2024, Therapeutic Leave Policy reviewed and revised by Director of Operations. Inservice initiated with facility staff on May 26, 2024, on updated Therapeutic Leave Policy by Assistant Director of Nursing. On May 25, 2024, Missing Resident and Elopement Policy reviewed by Director of Operations with no changes. Inservice initiated with facility staff on May 25, 2024, on Missing Resident and Elopement Policy by Assistant Director of Nursing. Inservice initiated with facility staff on May 26, 2024, on Reporting Incidents and Accidents by Assistant Director of Nursing. Inservice initiated with facility staff on May 26, 2024, on Emergency Intercom Codes by Assistant Director of Nursing. On May 26, 2024, Therapeutic Leave Form updated by Director of Operations and implemented immediately by Registered Nurse. Inservice initiated with facility staff on May 26, 2024, on updated Therapeutic Leave Form by Assistant Director of Nursing. On May 26, 2024, Elopement Drills were conducted on all shifts by Maintenance Supervisor. On May 26, 2024, Quality Assurance meeting held with Medical Director, Administrator, Corporate Nurse Consultant, Registered Nurse, Director of Nursing, Assistant Director of Nursing/Infection Preventionist, and Registered Nurse Supervisor. On May 26, 2024, 100% audit of all residents' elopement risk assessments, elopement book, wander guard physician orders, and

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| F 689 | Continued From page 3<br>revealed that during the investigation of the incident, they found out that Licensed Practical Nurse (LPN) #1 was working that night, 05/24/24, that he answered the doorbell and Resident #1's friend reported to him that he brought Resident #1 back to the facility, but the resident took off down the street. The ADM revealed that during the investigation, they found out that Resident #1's friend had checked him out of the facility earlier that day to go to the bank and that the resident had called the facility around 11:16 PM and said he wasn't coming back. She revealed that at 11:48 PM Resident's friend called the facility and said that he had talked Resident #1 into returning to the facility, returned him to the facility and that Resident #1 took off walking down the street when he got out of the vehicle. The ADM revealed that she reviewed camera footage when she came in on the morning of 05/25/24 and saw that Resident #1 exited the parking lot of the facility at 11:57 PM, crossed the street and last saw him in the parking lot of the eye clinic across the street from the facility.<br><br>On 06/03/24 at 10:20 AM, an interview with Resident #1 revealed that he felt better since he had been at the facility and wanted to go home. He revealed that he had a friend who picked him up last week and took him to the bank and stated, "I got out of here." Resident #1 revealed that his friend brought him back to the nursing home and he left walking. He revealed that he walked to the (Proper Name), got a cup of coffee and then went out back behind the bowling alley, sat all night and watched the sun come up. Resident #1 revealed that the next day a cop came by and let him sit in the backseat of his car and cool off. Resident #1 revealed that he went to the hospital for a couple of days, and they brought him back | F 689 | elopement care plans performed by Corporate Nurse Consultant. On May 27, 2024, exit doors and wander guard system checked for proper function by Maintenance Supervisor.<br><br>IV. Maintenance Supervisor will check operation of door monitors and wander guard system weekly for four weeks and monthly for two months beginning the week of May 27, 2024.<br>Registered Nurse will audit elopement risk book weekly for four weeks and monthly for two months beginning the week of June 17, 2024.<br><br>Registered Nurse will audit five residents' risk assessment for accuracy weekly for four weeks and monthly for two months beginning the week of June 17, 2024.<br><br>Administrator to review timeline of notifications to Administrator and Director of Nursing of incidents weekly for four weeks and monthly for two months beginning the week of June 17, 2024.<br><br>Findings of the audits will be reviewed by facility Administrator upon completion and presented monthly to the facility Quality Assurance Committee for further review and recommendation to ensure ongoing compliance beginning May 26, 2024 and then monthly for three months. | |

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to the nursing home. He stated, "I don't want to be here now, and if they give me half a chance, I'll leave again. I don't like being here." He revealed that this place was okay, and they took care of him, but he wanted to go home.

On 06/03/24 at 11:48 AM, a phone interview with LPN #1, revealed that he was working on the night of 05/24/24 and that Resident #1 was checked out and not in their care. He revealed that around 12:00 AM, he answered the doorbell and Resident #1's friend told him that he had brought Resident #1 back to the facility and that Resident #1 had jumped out of the car and started running towards the road. LPN #1 revealed that he went to the nursing station, told Charge Nurse and she called the Nursing Supervisor to see how to handle the situation. LPN #1 revealed that it was five to ten minutes before the Nursing Supervisor got back with them and she instructed them to put a note in the computer about what the guy said at the door and let him go since Resident #1 was still out on leave. LPN #1 revealed that he went outside and looked around the parking lot and didn't see him. LPN #1 revealed that he did what they told him to do at that particular time. He stated, "Didn't none of us know what to do."

On 06/03/24 at 2:00 PM, an interview with Certified Nursing Assistant (CNA) Supervisor, revealed that she was working on 05/24/24 on the night shift. She revealed that she answered the phone around 11:00 PM from Resident #1 who told her that he was not coming back to the facility because he had a lot of work to do around his house and he would return in the morning. CNA Supervisor revealed that she reported this phone call to Charge Nurse who told her that

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Resident #1 was in his right mind and that was his right. CNA Supervisor revealed that she sent a text to DON, letting her know that Resident #1 wasn't returning to the facility that night. CNA Supervisor revealed that she heard the next day about Resident #1 being returned by his friend to the facility and that he walked away. The CNA Supervisor revealed that this should have been handled differently. She revealed that had she known, she would have gone outside, looked for him, called 911, and called the Administrator. The CNA Supervisor revealed that Resident#1 was out on the streets all night and everyone should have been out looking for him. She stated, "He was on this property, they (facility staff) knew he belonged at the facility, and he was our responsibility." The CNA Supervisor revealed that she was so glad that he was safe, and nothing happened to him.

On 06/03/24 at 2:10 PM, a phone interview with the Charge Nurse, revealed that she worked a double shift on 05/24/24. She revealed that Resident #1 had been out on leave and had called late that night saying he wasn't coming back because he had things to take care of. She revealed that about an hour later, Resident #1's friend called and said he was on his way back to the facility with Resident #1. The Charge Nurse revealed that they were really busy that night and that LPN #1 had come to the nurse's station just before midnight and reported that a man came to the door, was out in the parking lot, had brought Resident #1 back to the facility and that Resident #1 had left on foot. She revealed that she wasn't sure how to handle this situation, so she went through the proper chain of command and called the Nursing Supervisor. The Charge Nurse revealed that the Nursing Supervisor told them to

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put a note in the computer about what the resident's friend said since Resident #1 hadn't come back into the building. The Charge Nurse revealed that she clocked out at the end of her double shift and rode around for twenty minutes looking for Resident #1. She revealed that she went to the hospital, through parking lots, neighborhoods using fog lights and did not see him anywhere. The Charge Nurse revealed that if she had it to do over again, she would have called everyone on her list including the DON and Administrator and would have been "out the door like lightning looking for him." She revealed that they should have called the DON or Administrator with this situation. The Charge Nurse revealed that Resident #1 could have been in a ditch, hit by a car, could have been hurt and that's why she went out and looked for him.

On 06/03/24 at 2:50 PM, an interview with DON, revealed that she received a phone call about 7:30 AM on 05/25/24 from the Nursing Supervisor who reported that Resident #1 came back to the facility on the night of 05/24/24 just before midnight and that he walked away. The DON revealed that she informed the Nursing Supervisor that she should have notified the authorities and called administration when it happened so they could have looked for him and started the elopement process. The DON revealed the Nursing Supervisor told her that she thought about calling 911 at the time of the incident but did not since Resident #1 was out on therapeutic leave. The DON revealed that Resident #1 had been signed out on pass, but he was still their responsibility because he was there at the facility. The DON revealed they called the authorities, called in help, and dispersed staff in pairs out to look for the resident. She revealed

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that the police found Resident #1 sitting on the ground beside the bowling alley at 1:00 PM on 05/25/24 and he had no injuries. The DON confirmed that this should have been handled differently, that they should have notified the administration and should have called 911 when Resident #1 left the premises on foot.

Record review of Resident #1's "Facesheet" revealed that he was admitted on 03/06/2024 and had diagnoses that included Malignant Neoplasm of Rectum, Pain, and Severe Protein-Calorie Malnutrition.

Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date of 03/12/2024, Section C revealed a Brief Interview for Mental Status (BIMS) score of 12 which indicated that he had moderate cognitive impairment.