STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255297	A. BUILDING _____ B. WING _____	C 10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 CAHAL STREET HATTIESBURG, MS 39401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation (CI MS #26878), at the facility from 10/28/24 through 10/29/24. The complaint was investigated regarding resident safety and neglect. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F600, F609, and F610. The facility held a license for 80 beds and had a census of 75 at the time of the survey.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure a resident was free from neglect, as evidenced by, on 10/21/24, at approximately 2:45 PM, after returning to an outing at a local fair, a resident was left in the facility's transportation van until	F 600	Resident #1 was located and removed from the facility van, the van was cleared with no other residents present, Resident #1 was assessed by nursing staff on 10/21/2024 and Resident #1 was assessed by the Nurse Practitioner on	11/19/24

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

Electronically Signed | 11/06/2024

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F 600	Continued From page 1 approximately 5:00 PM, for one (1) of three (3) sampled residents. Resident #1 Findings include: A review of the facility's policy, "Abuse Prevention Program," modified 8/2/22, revealed " ...Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation ..." On 10/28/24 at 11:20 AM, during an interview with the Administrator, he stated that on 10/21/24, following a trip to a local fair, five (5) residents were in the facility's transportation van. At approximately 2:45 PM the van returned to the facility and all the residents were unloaded except Resident #1. The van driver, who is also responsible for central supply, was requested to retrieve supplies for another resident. The front desk staff reported she always had eyes on the resident, while the resident was in the van alone, which was approximately 20 minutes. The Administrator confirmed that the Director of Nursing (DON) called him on 10/21/24 and advised him that Resident #1 was found inside the facility van at approximately 5:00 PM. The Administrator also stated that although the facility had video surveillance, the surveillance system was not operational on 10/21/24. During an interview on 10/28/25 at 12:45 PM, the van driver stated that on 10/21/24 at approximately 2:45 PM, he arrived at the facility with five (5) residents. Resident #1 was the only resident who was in a wheelchair. During their return to the facility as the residents were exiting, the van driver was called to get supplies for another resident, leaving Resident #1 in the van.	F 600	10/21/2024. There were no injuries, illnesses, or complaints identified or voiced by the staff, provider, or Resident #1 on 10/21/2024. All residents who are transported via the facility van have the potential to be affected by the deficient practice. The Quality Assurance Committee (QAC) met on the morning of 10/22/2024 to discuss the events of 10/21/2024. It was the recommendation of the QAC to put into place a Final Transportation Vehicle Inspection and Log. This inspection is completed by the vehicle Driver and another Front Office Staff Member prior to the vehicle being parked and left unattended at the end of the transport. This Inspection includes but is not limited to inspection of the interior of the van to ensure no residents remain in the vehicle prior to the vehicle being parked and left unattended. The QAC also approved a Transportation Vehicle Inspection Log which is kept at the front desk and is to be completed once the inspection is completed and all transported residents are safely inside the facility. All transportation vehicle drivers and front office staff were in-serviced on the Transportation Vehicle Inspection and Log on 10/22/2024. The Transportation Vehicle Inspection and Log process was put into effect on 10/22/2024. The Administrator will audit the Transportation Vehicle Inspection Log 5 times weekly x 2 weeks, then once weekly	

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F 600	Continued From page 2	F 600		

He stated he was only gone for five (5) to six (6) minutes. Front Desk #1 informed him that she would watch Resident #1 while he went for supplies. Upon returning to the van, he assisted Resident #1 off the van and brought him to the front lobby.

On 10/28/24 at 12:55 PM, during an interview with Front Desk #1, she stated that while the van driver was getting supplies for another resident, she walked outside, then back inside, and kept eyes on Resident #1 the entire time he was in the van. Approximately 10 minutes later, the van driver returned and assisted the resident off the van.

On 10/28/24 at 1:32 PM, during a phone interview with Registered Nurse (RN) #1/Supervisor, she stated that on 10/21/24 at approximately 5:00 PM during the evening meal, she was informed the facility staff could not locate Resident #1. RN #1 explained that all staff began to search for Resident #1, both inside and outside of the facility. Certified Nurse Assistant (CNA) #1 stated that Resident #1 went to the fair earlier and went to the front of the facility and found Resident #1 in the locked van. She further explained that Licensed Practical Nurse (LPN) #1 retrieved the facility van keys from Front Desk #1 and opened the van. The van driver had returned to the facility and assisted with removing Resident #1 from the van. RN #1 stated the incident was reported to the Director of Nurses (DON), and the Nurse practitioner (NP) was notified.

During an interview on 10/28/24 at 2:01 PM with LPN #2, she confirmed that on 10/21/24 during dinner time at the facility, Resident #1 was not present in the dining room, the staff went to

x 3 months beginning 10/22/2024 to ensure all inspections are being performed daily. Audits will be reviewed by the QAC monthly x 3 months beginning 11.18.2024 to ensure sustained compliance.

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F 600	Continued From page 3	F 600		

search for him and found him in the facility van. The van was locked, and LPN #1 received the keys from the front desk staff and opened the van. Someone had called the van driver back to the facility and he came and assisted in getting Resident #1 out of the van, which was at approximately 5:00 PM.

On 10/28/24 at 2:10 PM, during a phone interview with CNA #1, she revealed that when she realized Resident #1 was not in the dining room during the evening meal, she remembered he had gone with the other residents to the local fair. She immediately went to the van, which was in the handicapped parking spot, and saw him inside the van. CNA #1 recalled that a nurse got the keys from the front desk staff and the van driver assisted with getting the resident off the van and into the facility.

On 10/28/24 at 3:15 PM, during an interview with CNA #2, she stated that on 10/21/24 at approximately, 4:00 PM, she observed Resident #1 in the front lobby playing basketball.

On 10/28/24 at 3:24 PM, during a phone interview with LPN #1, she stated that on 10/21/24, when the facility staff discovered that Resident #1 was missing, she searched his room and bathroom. When he was found to be locked in the facility van, she got the keys from the front office to get him out of the van. She said the van was parked in its designated parking spot. She explained that someone had called the van driver to assist with getting the resident out. LPN #1 further explained that when the residents returned from the fair, she had documented that Resident #1 had returned in the computer system but admitted that she had not actually observed him in the

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F 600	Continued From page 4	F 600		

facility.

On 10/28/24 at 3:40 PM, in a follow up interview with Front Office #1, she recalled giving a nurse the van key on 10/21/24 sometime before she got off work at 6:00 PM but was unable to recall why the key was needed, the exact she gave the key out, and the name of the nurse she gave the key to because there was a lot of activity in the lobby.

On 10/28/24 at 4:15 PM, during a follow up interview with the Administrator, he reiterated that following the outing to the fair, the residents returned to the facility on 10/21/24 between 2:15 to 2:30 PM. Later that day, after leaving the facility for the day, he received a phone call from the DON, informing him that she received a phone call at or around 6:00 PM stating that Resident #1 was alone in the van and that he had no injuries. The staff notified the Nurse Practitioner to assess the resident. The next day, he received statements from the van driver and Front Office #1. The Administrator stated that he concluded based off those two (2) interviews that the resident was in the van for less than an hour and was supervised the entire time. He explained that he trusted the van driver's statement because he had been employed at the facility for 19 years and Front Office #1 collaborated the statement. He admitted that he did not interview any of the nursing staff that had assisted Resident #1 off the van around 5:00 PM. He was also unaware that Front Office #1 had given the van key to a nurse around that same time. The Administrator was unable to explain the discrepancies in the statements made by the facility staff and the timeline of the event. The Administrator explained the facility held an emergency Quality Assurance (QA) meeting on

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F 600	Continued From page 5	F 600		

10/22/24 because a resident being left on the van for any amount of time could be an issue.

On 10/29/24 at 9:27 AM, an interview with the Nurse Practitioner (NP) revealed on 10/21/24 at approximately 6:00 PM, he received a phone call from RN #1, stating that Resident #1 was left in the facility van for an undetermined amount of time. The NP explained that he did not witness Resident #1 being left in the facility's van. His note on 10/21/24 reflected to the best of his knowledge at the time of the incident what had been reported by the nursing staff. The NP stated he had provided an addendum to his note to clarify that he had no knowledge of how long the resident was left on the van. Following the incident as it was reported to him, he ordered basic blood work as the concern was that the resident had been left on the van for an undetermined amount of time.

On 10/29/24 at 9:57 AM, an interview with the DON confirmed on 10/21/24 at approximately 5:00 PM, she received a phone call from RN #1, stating that Resident #1 was missing but that he had been found in the facility van. The NP was notified, and she had called the Administrator to let him know what the RN Supervisor had reported. She stated the facility completed in-services regarding completing documentation correctly since LPN #1 admitted that she had documented Resident #1 as being in the facility on 10/21/24 without seeing him. The facility also completed in-services on Abuse and Neglect.

On 10/29/24 at 10:03 AM, in a follow up interview with RN #1, she stated that when it was reported to her that Resident #1 was missing, all staff started searching resident rooms, the shower

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room, and the outside courtyard. She did not issue a missing resident alert because he was found in the facility van. She confirmed that she went outside to the van and both the back and front door was open. She confirmed she observed the van driver return to the facility in his truck, and he was wearing a white t-shirt and shorts.

In a follow up interview with LPN #1 on 10/29/24 at 5:15 PM, she stated she found Resident #1 in the facility van, secured in a seatbelt, and the van door was locked. She explained she went and got the keys from Front Office #1, and another staff member called the van driver, who quickly arrived back to the facility.

A record review of the "Admission Record" revealed the facility admitted Resident #1 on 6/24/23 with diagnosis including Unspecified Intellectual Disabilities and Dementia.

A record review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/27/24, revealed Resident #1 had a Brief Interview of Mental Status (BIMS) score of 6, which indicated his cognition was severely impaired.

A record review of the "Quality Assessment and Assurance Committee Minutes October 22, 2024" revealed, " ...Emergency QA meeting held related to resident being left in a van. The driver of the van parked the vehicle in the front parking @ (at) the front entrance of the facility but failed to unload the resident. The amount of time the resident was in the van is unknown exactly, but it wasn't greater than 1 (one) hour ..."

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F 600	Continued From page 7 Record review of the "Progress Note" from the NP, dated 10/21/24, revealed, " ...Patient seen today per facility request for environmental exposure, apparently left in transport van. I was contacted approximately 1800 (6:00 PM) hours by facility nursing staff regarding the patient spending several hours in the van after going to the fair ...At approximately 19:30 (7:30 PM) I came and evaluated the patient ...Document e-signed ...on Oct 22 2024 ..." Record review of the "Addendum" from the NP Progress Note revealed, "Addendum is made to give this note to more accurately reflect appropriate timeline. It should be noted that I was not a witness to the events described above. The amount time that the patient was been in the van at this time is indeterminate, however he was at the fair and overall outside facility for several hours ...Document e-signed on Oct 29 2024 ..."	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other	F 609		11/19/24

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F 609	Continued From page 8 officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to report a violation of neglect within 24 hours when the facility was notified that a resident had been left in a facility van for an undetermined amount of time for one (1) of three (3) residents. Resident #1 Findings include: A review of the facility's policy, "Abuse Investigation and Reporting Prevention Program," modified 8/2/22, revealed, " ...All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local, state and federal agencies ...Reporting ...2. An alleged violation of abuse, neglect ...will be reported immediately, but not later than ...b. Twenty-four (24) hours if alleged violation does not involve abuse AND has not resulted in serious bodily injury ..." During an interview with the Administrator on	F 609	Resident #1 was located and removed from the facility van, the van was cleared with no other residents present, Resident #1 was assessed by nursing staff on 10/21/2024 and Resident #1 was assessed by the Nurse Practitioner on 10/21/2024. There were no injuries, illnesses, or complaints identified or voiced by the staff, provider, or Resident #1 on 10/21/2024. The Facility Administrator failed to report the possible neglect within 24hrs when the facility was notified that the resident had been left in a facility vehicle for an undetermined amount of time. All residents have the potential to be affected by the deficient practice. On 10/29/2024 the Administrator and Director of Nursing were in-service on the policies titled Abuse Investigation and Reporting and Abuse Prevention Program by the Corporate Compliance Officer at	

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F 609	Continued From page 9 10/28/24 at 4:15 PM, he stated that following the outing to the fair, the residents returned to the facility on 10/21/24 between 2:15 PM to 2:30 PM on the facility's transportation van. He confirmed that later that day after leaving the facility, he received a phone call from the Director of Nursing (DON) informing him that she had received a phone call at or around 6:00 PM from the facility staff stating that Resident #1 was alone in the van and that he had no injuries. The staff notified the Nurse Practitioner (NP) to assess the resident. The next day, he received statements from the van driver and Front Office #1 and he concluded based off those two (2) interviews that the resident was in the van for less than an hour and was supervised the entire time. He explained that he trusted the van driver's statement because he had been employed at the facility for 19 years and Front Office #1 collaborated the statement. He admitted that he did not interview any of the nursing staff that had assisted Resident #1 off the van around 5:00 PM. However, he felt that since the facility always had eyes on the resident and his investigation was completed, he did not need to report the event to the State Agency (SA). During an interview on 10/29/24 at 9:57 AM, the DON, confirmed that on 10/21/24 at approximately 5:00 PM, she received a phone call from RN #1, stating that Resident #1 was missing but had been found in the facility van. She notified the Administrator, but did not report or investigate the event because the Administrator stated he would do the investigation. A record review of the "Admission Record" revealed the facility admitted Resident #1 on 6/24/23 with diagnoses including Unspecified	F 609	the Corporate Office. The facility Staff Development Nurse educated all staff on the policies titled Abuse Investigation and Reporting and Abuse Prevention Program beginning on 10/22/2024. Monitoring of all incidents and accidents during facility Leadership Meeting each morning, Monday through Friday is an ongoing process. Beginning 10/29/2024, any suspected abuse or neglect will be discussed immediately with the Corporate Compliance Team at the Corporate Office to ensure proper reporting is conducted timely and proper investigative procedures are completed to ensure sustained compliance. The Director of Nursing will audit the Incident Log 5 times weekly x 2 weeks, then once weekly x 3 months beginning 10/22/2024. Audits will be reviewed by the QAC monthly x 3 months beginning 11.18.2024 to ensure sustained compliance.	

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Intellectual Disabilities and Dementia.

A record review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/27/24, revealed Resident #1 had a Brief Interview of Mental Status (BIMS) score of 6, which indicated his cognition was severely impaired.

A record review of the "Quality Assessment and Assurance Committee Minutes October 22, 2024" revealed, " ...Emergency QA (Quality Assessment) meeting held related to resident being left in a van. The driver of the van parked the vehicle in the front parking @ (at) the front entrance of the facility but failed to unload the resident. The amount of time the resident was in the van is unknown exactly, but it wasn't greater than 1 (one) hour ..."

Record review of the "Progress Note" from the NP, dated 10/21/24, revealed, " ...Patient seen today per facility request for environmental exposure, apparently left in transport van. I was contacted approximately 1800 (6:00 PM) hours by facility nursing staff regarding the patient spending several hours in the van after going to the fair ...At approximately 19:30 (7:30 PM) I came and evaluated the patient ...Document e-signed ...on Oct 22 2024 ..."

Record review of the "Addendum" from the NP Progress Note revealed, "Addendum is made to give this note to more accurately reflect appropriate timeline. It should be noted that I was not a witness to the events described above. The amount time that the patient was been in the van at this time is indeterminate, however he was at the fair and overall outside facility for several

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F 609	Continued From page 11 hours ...Document e-signed on Oct 29 2024 ..."	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to conduct a thorough investigation related to a resident who was left on the facility's transportation van upon return from an outing for one (1) of 3 (three) sampled residents. Resident #1 Findings include: A review of the facility's policy, "Abuse Investigation and Reporting," modified 8/2/22, revealed, " ...All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown	F 610	Resident #1 was located and removed from the facility van, the van was cleared with no other residents present, Resident #1 was assessed by nursing staff on 10/21/2024 and Resident #1 was assessed by the Nurse Practitioner on 10/21/2024. There were no injuries, illnesses, or complaints identified or voiced by the staff, provider, or Resident #1 on 10/21/2024. The Facility Administrator failed to report the possible neglect within 24hrs when the facility was notified that the resident had been left in a facility vehicle for an undetermined	11/19/24

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	255297	A. BUILDING _____ B. WING _____	C 10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 CAHAL STREET HATTIESBURG, MS 39401

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F 610	Continued From page 12 source ("abuse") shall be ...thoroughly investigated by facility management ...Policy Interpretation and Implementation Role of the Administrator: 1. If an incident or suspected incident of resident ...neglect ...is reported, the Administrator or designee will lead the investigation ...Investigative Process: 1. The individual conducting the investigation will, as a minimum ...c. Interview the person(s) reporting the incident; d. Interview any witnesses to the incident ...g. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident ...j. Review all events leading up to the alleged incident ..." The Administrator stated during an interview on 10/28/24 at 11:20 AM, that on 10/21/24, following a trip to a local fair, five (5) residents were in the facility's transportation van. At approximately 2:45 PM the van returned to the facility and all the residents were unloaded except Resident #1. The van driver, who is also responsible for central supply, was requested to retrieve supplies for another resident. The front desk staff reported she always had eyes on the resident, while the resident was in the van alone, which was approximately 20 minutes. The Administrator confirmed that the Director of Nursing (DON) called him on 10/21/24 and advised him that Resident #1 was found inside the facility van at approximately 5:00 PM. The Administrator also stated that although the facility had video surveillance, the surveillance system was not operational on 10/21/24. The Administrator reiterated on 10/28/24 at 4:15 PM, during a follow up interview that following the outing to the fair, the residents returned to the	F 610	amount of time. All residents have the potential to be affected by the deficient practice. On 10/29/2024 the Administrator and Director of Nursing were in-service on the policies titled "Abuse Investigation and Reporting" and "Abuse Prevention Program" by the Corporate Compliance Officer at the Corporate Office. The facility Staff Development Nurse educated all staff on the policies titled "Abuse Investigation and Reporting" and "Abuse Prevention Program" beginning on 10/22/2024. Monitoring of all incidents and accidents during facility Leadership Meeting each morning, Monday through Friday is an ongoing process. Beginning 10/29/2024, any suspected abuse or neglect will be discussed immediately with the Corporate Compliance Team at the Corporate Office to ensure proper reporting is conducted timely and proper investigative procedures are completed to ensure sustained compliance. The Director of Nursing will audit the Incident Log 5 times weekly x 2 weeks, then once weekly x 3 months beginning 10/22/2024. Audits will be reviewed by the QAC monthly x 3 months beginning 11.18.2024 to ensure sustained compliance.	

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F 610	Continued From page 13	F 610		

facility on 10/21/24 between 2:15 to 2:30 PM. He confirmed that later that day, after leaving the facility, he received a phone call from the DON, informing him that she received a phone call at or around 6:00 PM stating that Resident #1 was alone in the van and that he had no injuries. The staff notified the Nurse Practitioner to assess the resident. The next day, he received statements from the van driver and Front Office #1 and he concluded based off those two (2) interviews that the resident was in the van for less than an hour and was supervised the entire time. He explained that he trusted the van driver's statement because he had been employed at the facility for 19 years and Front Office #1 collaborated the statement. He admitted that he did not interview any of the nursing staff that had assisted Resident #1 off the van around 5:00 PM or any other facility staff that may have witnessed the incident. He also did not interview staff members on all shifts who had contact with the resident during the period of the alleged incident. The Administrator was unable to explain the discrepancies in the statements made by the facility staff and the timeline of the event. He stated that since the facility staff always had eyes on the resident, the investigations was completed, unsubstantiated, and required no further investigation.

The DON confirmed during an interview on 10/29/24 at 9:57 AM, that on 10/21/24 at approximately 5:00 PM, she received a phone call from RN #1, stating that Resident #1 was missing but had been found in the facility's van. She notified the Administrator, but did not report or investigate the event because the Administrator stated he would do the investigation.

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F 610	Continued From page 14	F 610		

A record review of the "Admission Record" revealed the facility admitted Resident #1 on 6/24/23 with diagnoses including Unspecified Intellectual Disabilities and Dementia.

A record review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/27/24, revealed Resident #1 had a Brief Interview of Mental Status (BIMS) score of 6, which indicated his cognition was severely impaired.

A record review of the "Quality Assessment and Assurance Committee Minutes October 22, 2024" revealed, " ...Emergency QA (Quality Assessment) meeting held related to resident being left in a van. The driver of the van parked the vehicle in the front parking @ (at) the front entrance of the facility but failed to unload the resident. The amount of time the resident was in the van is unknown exactly, but it wasn't greater than 1 (one) hour ..."

Record review of the "Progress Note" from the NP, dated 10/21/24, revealed, " ...Patient seen today per facility request for environmental exposure, apparently left in transport van. I was contacted approximately 1800 (6:00 PM) hours by facility nursing staff regarding the patient spending several hours in the van after going to the fair ...At approximately 19:30 (7:30 PM) I came and evaluated the patient ...Document e-signed ...on Oct 22 2024 ..."

Record review of the "Addendum" from the NP Progress Note revealed, "Addendum is made to give this note to more accurately reflect appropriate timeline. It should be noted that I

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F 610	Continued From page 15 was not a witness to the events described above. The amount time that the patient was been in the van at this time is indeterminate, however he was at the fair and overall outside facility for several hours ...Document e-signed on Oct 29 2024 ..."	F 610		