| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255115 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 09/18/2025 |
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| F0000 | INITIAL COMMENTS<br><br>The State Agency (SA) conducted complaint investigations (CIs) at the facility for CI MS#2605137, Incident #2612501 and CI MS #2618796 from 9/15/25 through 9/18/25. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid related to CI MS #2618796 for quality of care and cited F684. The SA investigated CI MS# 2605137 for rehabilitation services and resident rights with no deficiencies cited. The SA investigated Incident #2612501 and cited F689 at Immediate Jeopardy (IJ) – Past Noncompliance.<br><br>The SA identified Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), Past Noncompliance, that began on 9/8/25 when facility staff failed to provide adequate supervision for Resident #9 resulting in the elopement of the resident.<br><br>The facility's noncompliance placed this resident and all residents who wander at risk for serious harm, serious impairment, serious injury or death.<br><br>IJ and SQC existed at:<br><br>CFR 483.25(d)(2) Accidents/Hazards - F689 - Scope/Severity "J"<br><br>The facility Administrator was notified of the IJ and SQC on 9/17/25 at 4:15 PM and was presented with the IJ templates.<br><br>The facility provided an acceptable Corrective Action Plan on 9/18/25, in which they alleged all corrective actions to remove the IJ and SQC were completed on 9/09/25 prior to SA entrance on 9/15/25, and the IJ removed on 9/10/25.<br><br>The SA validated the Corrective Action Plan on 9/18/25 and determined that the IJ was removed on 9/10/25, prior to SA entrance on 9/15/25.<br><br>The facility had a license for 180 beds, with a census of 165 residents. | F0000 | | |
| F0684<br>SS=D | Quality of Care | F0684 | | |

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| F0684 SS = D | Continued from page 1<br><br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br><br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview, record review, and policy review the facility failed to provide needed care and services that would meet the resident's physical needs as evidenced by wound care not provided in one (1) of two (2) sampled residents with wounds. Resident #4.<br><br>Findings include:<br><br>Record review of the facility policy titled “Wound Care Treatment Protocol” (no review date) revealed the policy instructed staff to: “Evaluate the wound daily for signs and symptoms of infection and for signs of healing. Document/Report Findings. Provide treatment as per physician's order.”<br><br>On 09/17/2025 at 9:22 AM, during an interview Resident #4 stated "My wound care should be done every 3 days. It was done on 09/11/25 but not on 09/14/25. They just wipe it with wet gauze and cover it up. It’s supposed to be irrigated with Dial soap. There’s a doctor who sees wounds, but he’s never looked at mine.”<br><br>Record review of Resident #4’s electronic Treatment Administration Record (eTAR) for September 2025 revealed a physician order for treatment with a start date of 9/8/2025 “Mupirocin External Ointment 2% Apply to left lateral ankle topically every day shift every (3) days for wound. Clean left lateral ankle with normal saline, pat dry, apply Mupirocin, cover with Mepilex every 3 days.” The eTAR indicated wound care was provided on 09/11/2025, but not documented as provided on 09/14/2025, as evidenced by the absence of staff initials in the designated treatment box for that date.<br><br>On 09/17/2025 at 9:34, during an interview the Director of Nursing (DON) revealed that the facility physician typically evaluates wounds, however, Resident #4 refuses the facility physician and instead is seen | F0684 | | |

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| F0684<br>SS = D | Continued from page 2<br>weekly at the Wound Clinic.<br><br>On 09/17/2025 12:12 PM, in an interview Licensed Practical Nurse (LPN) #1/ Unit Manager reported that a as needed (PRN) order had been obtained for the prescribed wound care and that she administered the dressing on 09/15/2025. She added that the dressing she removed was not signed, dated, or timed, contrary to protocol.<br><br>During an interview on 09/17/2025 at 3:15 PM, LPN #2/Treatment Nurse revealed that she was unaware why the wound care was missed on 09/14/2025 and stated that she only works weekdays.<br><br>During a joint interview on 09/18/2025 at 3:15 PM, the Administrator and Director of Nurses (DON) acknowledged that wound care had not been completed on 09/14/2025 and confirmed their understanding of the importance of adhering to physician orders.<br><br>Record review of Resident #4's "Admission Record" revealed he was admitted to the facility on 11/01/2024 with diagnoses including Diabetes Mellitus, Non-pressure Chronic Ulcer of Unspecified Lower Limb, and Vascular Dementia.<br><br>Record review of Resident #4's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/22/2025 indicated in Section M the presence of a non-pressure ulcer. Section C indicated Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. | F0684 | | |
| F0689<br>SS = SQC-J | Free of Accident Hazards/Supervision/Devices<br><br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br><br>The facility must ensure that -<br><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><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interviews, record review and facility policy review, the facility failed to provide | F0689 | "Past Noncompliance - no plan of correction required" | |

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| F0689 SS = SQC-J | Continued from page 3<br>adequate supervision and a secure environment to prevent the elopement of one (1) of six (6) sampled residents, Resident #9.<br><br>On 9/08/25 a newly admitted respite resident with diagnoses of restlessness and agitation, dementia and senile degeneration of brain and history of exit seeking behaviors and falls was assisted to exit the facility by staff, was outside unsupervised for twenty-five (25) minutes until a staff member observed the resident lying on the ground next to the iron fence that encircled the facility premises, approximately three hundred seventy-five (375) feet from the facility entrance.<br><br>The facility's failure to provide adequate supervision to prevent the elopement of Resident #9 placed this resident, and other residents at risk for wandering and elopement, in a situation that was likely to cause serious injury, harm, impairment, or death. While Resident was out of the facility unsupervised in the parking lot and driveway area of the facility at shift change, she was observed laying on the ground.<br><br>The facility's failure to identify the need for adequate supervision and ensure a secure environment contributed to Resident #9's elopement and placed all residents who were admitted with or developed wandering/exit seeking behaviors at risk. This failure resulted in Immediate Jeopardy and Substandard Quality of Care (SQC) which began on 9/08/25. The SA notified the facility's Administrator of the IJ and SQC on 09/17/2025 at 4:15 PM and provided the Administrator with the IJ templates. Based on the facility's implementation of corrective actions on 9/9/25, the State Agency (SA) determined the IJ and SQC to be Past Non-compliance (PNC) and the IJ removed on 9/10/25, prior to the entrance of the SA on 9/15/25.<br><br>Findings include:<br><br>Record review of the facility policy titled, "MISSING RESIDENT/ELOPEMENTS" with a review date of 1/15 (January 2015) revealed "POLICY: The Unit charge Nurse is responsible for knowing the location of their residents…RESPONSIBILITY: The Charge Nurses and all other staff. 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/CMT as soon as practical. 2. Should an employee observe a resident leaving the premises, he/she should: a. Attempt to prevent the departure; b. Obtain assistance from other staff members in the immediate vicinity, if necessary…" | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 4<br><br>Record review of the Progress Notes for Resident #9 dated 9/08/25 revealed that the Director of Nurses (DON) documented, “Resident assisted outside by staff…Resident is a new admission to facility 9/08/25. MD/RP notified. New order for wander guard and one on one monitoring.”<br><br>Record review of the “Supervisor Investigation Summary Form: (facility investigation) and 9/16/25 observation at 2:06 PM during interview with Certified Nurses’ Aide (CNA) #1 revealed that on 9/08/25 at approximately 2:53 PM the (former) Receptionist assisted Resident #9 out the front door. The resident walked around the grounds, sat on a bench for a while and then walked to and up the northwestern driveway toward the street and was located at approximately 3:30 PM laying on the ground on the west side of the northwest driveway, next to the iron fence that circumvented the facility property, approximately fifty-five (55) feet from the street and approximately three hundred seventy-five feet from the facility’s front entrance. According to CNA #1 and the facility investigation, Resident #9 was assisted to stand and walk up the incline to a grassy area on the side of the driveway with a wheelchair brought to return the resident into the facility.<br><br>On 9/16/25 at 2:06 PM, during an observation of the area Resident #9 was located in on 9/8/25 and interview with CNA #1 revealed that on 9/08/25 at approximately 3:15 PM she had gotten into her car after clocking out and was leaving the premises when she observed what she described as “looked like a pile of clothes at first” laying on the ground inside the northwest corner of the black metal fence that encircled the facility. She stated that as she looked, she realized it was a person lying on the ground. She stated she stopped and summoned assistance. She and CNA #2 assisted Resident #9 to stand and walk to the grassy area uphill and next to the driveway from the area she initially saw her. CNA #1 said that she and CNA #2 routinely worked on the second floor of the facility and were not familiar with the resident, so they asked questions to determine if she was a facility resident. She said that Resident #9 told them that she did not live at the facility, had driven herself to the facility and that her car was on the second floor with her daughter. CNA #1 said that she then summoned the DON and Assistant Director of Nursing (ADON), who identified Resident #1. Staff assisted the resident to return to the facility at approximately 3:25 PM. CNA #1 reported that the weather was clear, dry and warm temperature. CNA #1 described Resident #9 as wearing blue pants, a red/white/blue stripped shirt and a red sweater and house slippers. | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 5<br>She said she received in-service training provided by the facility following the elopement and participated in elopement drills.<br><br>On 9/16/25 at 2:30 PM during observation of the area Resident #9 was located on 9/08/25 and interview with CNA#2 stated that she had just clocked out following the 7:00AM to 3:00 PM (7-3) shift and got into her car in the front parking lot when she saw CNA #1 waving her hands and calling for assistance. She said she went toward CNA #1 and observed “someone” laying on the ground inside the northwest corner of the black metal fence that encircled the facility. She said she had not recognized the person on the ground, and she and CNA #1 talked with the woman and determined based on her appearance and confusion to summon the DON. CNA #2 said that the weather was clear, dry and warm.<br><br>On 9/17/25 at 9:34 AM, during an interview the DON confirmed that she had participated in the facility investigation into the elopement of Resident #9 on 9/08/25. She stated that on 9/08/25 the facility had placed the resident on one-on-one supervision, and the primary healthcare provider (PHP) had issued new orders for application and monitoring of a safe wandering device. She stated that during her investigation she interviewed the receptionist who reported that he had entered the code and escorted the resident outside and then returned inside without knowing if she was a resident. The DON said that CNA #1 had clocked out and was leaving the premises and observed the resident and she and CNA #2 summoned her (the DON) and assisted the resident back into the facility.<br><br>On 9/17/25 at 2:36 PM, during a telephone interview the Resident Representative (RR) for Resident #9 revealed that she had brought the resident to the facility on 9/08/25 for respite care. She said she was notified by the DON on the same day that Resident #9 had been assisted outside by staff and a short while later was observed by another staff member lying on the ground. She confirmed that she was notified of new orders for a safe wandering device and one-on-one supervision to prevent future elopements. She confirmed that the resident remained at the facility as planned throughout the respite period and returned home as planned. She confirmed that the resident had not been injured and said she had noted no physical or psychosocial changes in the resident following the incident.<br><br>On 9/17/25 at 3:23 PM, observation revealed the front entrance opened to a front porch under a portico which led to the paved front parking lot which was well-maintained. There was a well-maintained cement | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 6<br>sidewalk that spanned the front of the building. Observation revealed all parking spaces were full. The facility had an upper and lower driveway which led to the street. The speed limit of the street was twenty-five (25) miles per hour. There were eleven (11) vehicles observed traveling through the parking lot and an additional four (4) vehicles observed traversing the street in a five-minute period.<br><br>On 9/17/25 at 3:50 PM, during an interview Executive Director revealed that the facility had investigated the 9/08/25 elopement of Resident #9, and he and the interdisciplinary team determined that the root cause was that the Former Receptionist had unlocked the door and escorted and left Resident #1 outside without determination of the resident's identity as a resident, for which the Receptionist's employment at the facility had been terminated. The resident's RR and PHP were notified and the facility received new orders for a safe wandering device, and the resident was placed on one-on-one supervision until her discharge. He said in-service training and elopement drills were initiated for all staff and that the incident was reviewed during a Quality Assessment and Performance Improvement (QAPI) meeting on 9/09/25 and reported to state agency per state and federal requirements.<br><br>On 9/18/25 at 10:40 AM, during an interview LPN #3, the assigned Unit Manager for Resident #9 on 9/08/25 on first floor, stated that Resident #9 arrived on the unit accompanied by her RR at approximately 9:30 AM on 9/08/25. She stated that the resident was able to participate in Brief Interview for Mental Status (BIMS) but was only oriented to self (able to supply her own name). She stated that the RR had reported history of falls, but not wandering or elopement and that report coupled with the resident's dependence on wheelchair for locomotion resulted in an assessment of no risk for elopement. She stated that she last observed the resident around lunch time when she had assisted the resident to the first-floor dayroom for lunch. She stated that she was made aware of the elopement by the DON. LPN #3 confirmed that Resident #9's PHP had issued new orders for a safe wandering device with monitoring, and the resident was provided with one-on-one supervision for the remainder of her respite stay at the facility.<br><br>On 9/18/25 at 11:00 AM, a telephone interview with the former facility Receptionist revealed he manned the desk at the front entrance and there was a keypad in the receptionist office and one next to the front entrance door. He said he was able to enter the code into either and unlock the front entrance. He reported | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 7<br>that he was not aware that Resident #9 had been admitted because he arrived late at work and was not at the desk and had not witnessed her arrival. He explained that he released the lock on the front door and allowed Resident #9 to exit after seeing her push on the entrance door. He stated that he did not know who she was and had not asked. He said he had not noticed what type of footwear the resident was wearing. He said that he had worked at the facility as receptionist for a few weeks and confirmed that he had received training during orientation regarding keeping security codes confidential, residents at risk for wandering/elopement and dementia. He confirmed that his employment at the facility had been terminated because of the elopement.<br><br>Record review of the “Category One Violation Employee Corrective/Counseling Memorandum” dated 9/09/25 for the former Receptionist revealed documentation that his employment was terminated on 9/09/25 due to “Employee let a resident outside the facility without determining if resident was safe to exit or identify if this was a resident or not.”<br><br>Record review of the local weather history according to WWW.Wunderground, Copyright the Weather Channel, for the facility for 12:00 PM on 9/08/25 revealed the high temperature for the day was eighty-four (84) degrees Fahrenheit, with zero precipitation, four to twelve (4-12) mile per hour winds and clear.<br><br>Record review of the “Admission Record” for Resident #9 revealed the facility admitted the resident on 9/08/25 and the resident had diagnoses of restlessness and agitation, dementia with anxiety, senile degeneration of brain and heart failure.<br><br>Record review of the Admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) 9/13/25 for Resident #9 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 7, which indicated severe cognitive impairment.<br><br>Manhattan Corrective Action Plan validated by SA on 9/18/25:<br><br>On 9/08/25 around 2:53 pm, the receptionist assisted Resident #9 out the front door after which the resident was located approximately twenty-five minutes later laying on the ground in the northwest corner of the facility property.<br><br>Resident #9- | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 8<br>1. A second at risk for elopement assessment completed for Resident #9 on 9/8/25 at 3:15pm<br><br>2. Resident 9's Instant care plan and Kardex were updated on 9/8/25 at 3:15pm<br><br>3. One-on-one supervision orders received, and monitoring implemented on 9/8/25 at 3:15 pm<br><br>4. Resident #9's Instant care plan and Kardex were updated-9/8/25 at 3:15pm<br><br>5. Resident #9's Responsible Party (RP) and Primary Healthcare Provider were notified of the incident with safe wandering device bracelet orders received with bracelet applied on Resident #9 with orders for nurses to check placement and functioning every shift-9/8/25 at 3:15pm<br><br>6. Head to toe body audit was conducted for Resident #9 on 9/8/25 at 3:20pm<br><br>7. Temperature outside 9/8/25 at 3:00pm-clear and lower 80s<br><br>8. Distance from front door 375 feet - 9/8/25<br><br>On 9/08/25 nursing staff completed 100% head count of all residents not signed out on pass with all residents accounted for<br><br>Employee corrective counseling completed with former Receptionist on 9/9/25 at 8:00 am (Category 1 offence, employment terminated)<br><br>100% At risk for elopement evaluations completed on all residents on 9/8/25 through 9/9/25<br><br>100% in-service training started for all staff prior to working on - Elopement/Wandering, Abuse/Neglect, Behaviors, Adequate monitoring, Supervision- completed 9/09/25<br><br>Safe wandering devices for all residents wearing them are checked every shift for placement and functioning on 9/8/25<br><br>Elopement Drills were conducted on all shifts beginning on 9/8/25, 3:00 pm-11:00 pm (3-11) shift<br><br>100% audit of elopement books completed on 9/8/25<br><br>All doors checked for proper functioning on 9/8/25 | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 9<br>Security specialist contractor visited and checked doors for functioning on 9/9//25<br><br>Quality Assurance (QA) Meeting attended by all key personnel, which included but not limited to Executive Director, Director of Nurses, Infection Preventionist and Medical Director was held 9/9/25 with root cause analysis conducted and interdisciplinary team developed strategy to prevent future elopement incidents<br><br>Resident #9 to remain on 1:1 until discharge from facility; Discharged 9/13/25 at 1:10pm<br><br>Resident photos will be taken at the time of admission, regardless of elopement risk assessment results, and posted at the receptionist desk beginning 9/9/25<br><br>The facility alleges all corrective actions were completed on 9/9/25 and the Immediate Jeopardy was removed on 9/10/25<br><br>Monitoring included one-on-one monitoring/supervision of Resident #9 through discharge on 9/13/25 and the Admissions Coordinator to monitor the communication board in the reception office to ensure the board's accuracy and currently with all new admissions' photographs posted; continued elopement assessments of all newly admitted residents at the time of admission by nursing staff; continued monitoring of positioning and functioning of safe wandering devices worn by residents at risk of elopement every shift by nursing staff; continued daily monitoring of the safe wandering system functionality by the maintenance director; review of and development of care plans for all newly admitted residents with family/resident to evaluate for history of wandering/elopement for three (3) months with monitoring results and corrective actions reviewed at QA meetings for three (3) months (first QA meeting held following incident was 9/09/25 with subsequent QA meeting held 9/18/25)<br><br>On 09/18/25, SA validations were completed onsite during the complaint investigation through interviews, observations and record reviews that all corrective actions had been taken by the facility to remove the IJ and the IJ was removed on 09/10/25. | F0689 | | |