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THE CARROLTON OF LUMBERTON	**1170 LINKHAW ROAD LUMBERTON, NC 28358**

(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 A complaint investigation survey was conducted from 04/03/23 through 04/06/23. Event ID# FEGS11. The following intakes were investigated: NC00200204 NC00200421 3 of the 5 complaints resulted in deficiency. Intake NC00200204 and NC00200421 resulted in immediate jeopardy. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity K CFR 483.25 at tag F689 at a scope and severity K The tags F600 and F689 constituted Substandard Quality of Care. Immediate Jeopardy for F600 began on 03/11/23 and was removed on 04/05/23. Immediate Jeopardy for F689 began on 02/16/23 and was removed on 04/05/23. A partial extended survey was conducted.	F 000		
F 600 SS=K	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	F 600		4/21/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/27/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 600	Continued From page 1 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 staff and nurse practitioner interviews, observations, and record review, the facility failed to protect two vulnerable female residents right to be free from unwanted touching and intrusions into personal space by Resident #1 (Resident #6 and Resident #2). Resident #1 had severely impaired cognition, had behaviors, and was known to wander. On 3/11/23 Resident #1 was observed by Nurse #1 in Resident #6's room leaning over her bed with his hands pulling her shirt near her shoulders, their faces were inches apart, and Resident #1 had his lips pursed as though he was trying to kiss Resident #6 on her mouth. On 3/25/23 Resident #2 was heard calling out for help and when staff entered her room Resident #1 was observed naked from the waist down rubbing Resident #2's feet. These incidents initiated by Resident #1 had a high likelihood of causing serious physical injury to the victims. Resident #2 and Resident #6 did not have the cognitive ability to express an adverse outcome. A reasonable person expects to be protected from the presence of unwanted persons and advancements into their personal space in their home environment resulting in serious psychosocial harm with feelings such as intense fear, distress, and anxiety. This occurred for 2 of 3 residents reviewed for abuse (Resident #2, and Resident #6).	F 600	F 600 Freedom from Abuse, Neglect, Exploitation Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and Residents #6 and #2 are the most at risk for suffering adverse outcomes based on the facility□s failure to protect them from physical abuse and intrusion into their personal space with attempts for inappropriate sexual interactions. Resident #1 is the alleged abuser. All residents are at risk for suffering physical and /or psychosocial harm as a result of the deficient practice. Incidents will be reported to the state on 4/4/23. Actions taken to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.	

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Immediate Jeopardy (IJ) began on 3/11/23 when Resident #1 was found leaning over Resident #2 in her bed, pulling her by the shirt and appeared to be attempting to kiss her. Immediate Jeopardy was removed on 4/5/23 when the facility provided and implemented and acceptable credible allegation for IJ removal. The facility will remain out of compliance at a lower scope and severity level E (no actual harm with the potential for more than minimal harm that is not IJ) to ensure that education is completed and monitoring systems put into place are effective.

Findings included:

1. Resident #1 was admitted to the facility on 2/1/23 with diagnoses that included dementia with behavioral disturbance and anxiety disorder. His admission MDS dated 2/9/23 indicated he was severely cognitively impaired. He displayed physical behaviors directed at others 1 to 3 days of the review period and other behaviors not directed at others 4 to 6 days of the review period. Resident #1 was independent for walking and locomotion. He wandered 4 to 6 days of the review period.

A Care Plan dated 2/21/23 focused on behaviors related to Resident #1's episodes of combativeness towards staff, pacing, and going into other residents' rooms. Goals included Resident #1 will have fewer behaviors through the review period. Goals included administer medications as ordered, anticipate resident's needs, and monitor behavioral episodes and attempt to find an underlying cause.

A Psychiatry Initial Consult dated 2/2/23 indicated

F 600

On Tuesday, April 4, 2023 Resident #1 was relocated to a less populated hall to allow for more staff visibility from the Director of Nursing□s (DON□s) office, therapy suite, and nursing station.

This action will diminish wandering into other resident rooms. Should the wandering behavior present, the resident would have to cross the central corridor in the presence of the nursing station, DON□s office, and therapy suite thus allowing for redirection and intervention.

On Tuesday, April 4, 2023 Resident #1 was placed on 1:1 monitoring by a facility staff member. The monitoring will continue 24 /7 in order to ensure that all residents are free of adverse outcomes related to physical abuse and intrusion into their personal spaces. The resident was previously on 1:1 but was tapered to 15 minute checks when the incidents occurred. The monitoring will be increased to 24 / 7 the resident will be monitored at all times, including when the staff member takes breaks.

A full staff mandatory meeting for all direct care staff, management staff, and contracted staff was held on April 4, 2023 at 3:00 pm in the facility□s dining room.

The facility Administrator and members of the Corporate Operations, Managing Director and VP Property, and Corporate Clinical Nurse Consultant conducted the training session.

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staff reported Resident #1 was restless, anxious, agitated, and wandering. He was not sleeping. An as needed antianxiety medication was started.

Record review indicated Resident #1 was on 15-minute checks 2/16/23 through 3/12/23 following an elopement. Review of the documentation revealed staff signed a sheet with fifteen- minute increments indicating they were assigned to monitor Resident #1 for that time and date.

A telephone interview was conducted on 4/3/23 at 3:35 PM. Nurse #2 indicated that at the beginning of March 2023, Resident #1 was walking through a common are when another resident (from the assisted living section of the facility) reached her hand out to him. Resident #1 grabbed her wrist and twisted her arm behind her back. Staff directed him to let go and he hit her on the back of the head. The residents were separated. The other resident was "shaken", and the police were called. Nurse #2 added this was Resident #1's first physical interaction with another resident. Resident #1 had been on 1:1 supervision in the past for an elopement but was agitated having someone "following" him. The supervision was changed to 15-minute checks, and he did well with those.

1a. An Incident Report dated 3/11/23 (a Saturday) at 11:00 AM written by Nurse #1 indicated that Resident #1 was found leaning over Resident #6 in her bed.

Resident #6 was admitted to the facility on 12/22/22 with diagnoses that included failure to thrive, cognitive communication deficit, and malnutrition. Her admission Minimum Data Set

F 600

The DON was responsible for maintaining the list of attendees and on-going survey education.

No staff member will be allowed to provide care to residents or otherwise resume normal job roles until they complete the training.

Training topics included the following:

" Monitoring requirements for Resident # 1 to include reporting within 2 hours for allegations of abuse.

" Status of survey and interventions put in place.

" Training on the abuse policy and procedures to ensure full compliance with resident rights consistent with applicable state and federal law, specifically including the resident�s right to be free of abuse and proper abuse reporting.

" Retraining of facility and contracted staff to ensure awareness of:
Abuse definitions,
Abuse reporting,
Abuse allegation investigations,
Facility Policies
Residents right to be free of abuse
Protection of all residents at the time of incident occurrence
Notification to Administrator and corporate team of all allegations

The facility Administrator and Director of

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F 600	Continued From page 4 (MDS) dated 12/28/22 indicated moderate cognitive impairment. She required extensive assistance for bed mobility and transfers. Resident #1's Care Plan focus area for behaviors was updated on 3/11/23 to indicate 1:1 supervision due to entering a resident's room uninvited. No new interventions were put in place. During an interview on 4/3/23 at 3:20 PM, Nurse #1 indicated that on 3/11/23 around 11:00 AM, she found Resident #1 in Resident #6's room leaning over her bed with his hands pulling her shirt near the shoulder and their faces inches apart. When Nurse #1 got his attention, he looked at her then back to Resident #6, pulling her by the shirt with his lips pursed as though he was trying to kiss her mouth. Nurse #1 did not observe the residents' lips touching. A Nurse Aide (NA) was able to assist with getting Resident #1 out of the room. Resident #6 was upset, and Nurse #1 assisted her in calling her family member. Nurse #1 notified Resident #6's family member and the Director of Nursing (DON) by telephone. The DON advised her to fill out an incident report. Nurse #1 believed she put the pulling of the shirt and attempted kiss in her incident report. That was the first time she had seen Resident #1 touching another resident, but he did wander in and out of residents' rooms. Nurse #1 was unsure if Resident #1 was on 15-minute checks on 3/11/23. Nurse #1 indicated that staff monitored him throughout the day and intervened as needed. Resident #1 was usually able to be redirected. Record review indicated NA #5 had signed the 15-minute check off sheet for 3/11/23 from 11:00	F 600	Nursing are responsible for the full implementation of the immediate jeopardy removal plan. The corporate operations, clinical, and compliance team will support the Administrator and Director of Nursing. Date of Removal of Immediate Jeopardy: April 6, 2023 Since date of IJ removal DON and/or Administrator has completed 100% staff education on abuse policy and reporting effective 4/10/2023. Social Worker and/or designee will conduct resident abuse interviews with 2 residents weekly x 4 weeks and then monthly x 2 months or until QAPI committee deems compliance. Results of resident audits will be forwarded to the QAPI committee meeting monthly x 3 months or until deemed compliance. Any areas of concern will be corrected immediately.	

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AM to 1:00 PM (the time the incident occurred).

A telephone interview was conducted on 4/4/23 at 2:20 PM with the NA assigned to Resident #1 at the time of the incident. NA #5 could not recall if she was assigned to Resident #1 at the time of the incident on 3/11/23. She indicated that Resident #1 was calm when she worked with him, and she had not observed behaviors directed at other residents. NA #5 revealed Resident #1 usually walked the halls with her and did not attempt to go in other residents' rooms.

Resident #6 was sleeping during attempts to interview on 4/3/23 at 10:00 AM and at 4/5/23 at 10:25 AM.

1b. A Progress Note dated 3/25/23 (a Saturday) at 10:00 PM written by Nurse #3 indicated she heard Resident #2 calling out from her room. When she entered, she observed Resident #1 naked from the waist down pulling the covers off Resident #2 and touching her feet. Resident #1 did not leave the room when prompted. The police were called.

Resident #2 was admitted to the facility on 1/24/23 with diagnoses that included debility, malnutrition, and cognitive communication deficit. Her admission MDS dated 1/31/23 indicated moderate cognitive impairment. She required extensive assistance with bed mobility, transfers and was dependent on staff for locomotion.

A written statement from Nurse #3 indicated that on 3/25/23 (no time noted), she heard Resident #2 calling for help. Resident #1 was in her room naked from the waist down, pulling her bedding

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off and touching her feet. Nurse #3 attempted to get Resident #1 out of the room and was unsuccessful. Nurse #3 retrieved Nurse #4 for assistance. They were unsuccessful at getting Resident #1 out of the room. Nurse #3 left to call the police.

A telephone interview was conducted on 4/4/23 at 12:10 PM. Nurse #3 revealed that on 3/25/23 she heard someone calling out for help on the 300-hall. She arrived at Resident #2's room and Resident #1 had removed Resident #2's bedding and had removed the air mattress control box from the foot of her bed. Resident #1 was not attempting to hit Resident #2 and gave the box to Nurse #3 when prompted. Resident #1 was naked from the waist down and was rubbing Resident #2's feet. Resident#2 was upset and was crying out. When Nurse #3 told Resident #1 to leave, he ignored her. Resident #1 was getting clothes out of Resident #2's closet and putting it on her bed. Nurse #3 revealed she left the room to call the police and Nurse #4 stayed with the residents. Resident #1 was calm in his room when the police arrived, so they did not intervene. Nurse #3 revealed that Resident #1 had wandering behaviors prior. Earlier that evening, he was found on another hall in another resident's room going through their belongings. Nurse #3 revealed that last time she had seen him that evening he was resting in bed.

A progress note dated 3/25/23 at 10:00 PM written by Nurse #4 for the same incident added that after the other nurse left the room, Resident #1 was pulling clothes from Resident #2's closet and touching her feet. Resident #1 grabbed a plastic spoon with the handle pointing outward and tried to get around Nurse #4 to Resident #2

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in her bed. Nurse #4 pulled Resident #1 out of the room backwards by his t-shirt.

A written statement from Nurse #4 revealed that on 3/25/23 at approximately 9:30 PM, Nurse #3 came to the nurse's station requesting assistance. She could hear loud voices on the 300-hall. Resident #1 was naked from the waist down "rummaging" through Resident #2's belongings. Resident #2 was crying out. Resident #1 was pulling off Resident #2's bedding and rubbing her feet. Resident #2 was getting more upset. Resident #1 was not able to be redirected to leave the room. Nurse #3 left to call the police. Resident #1 continued pulling things from the closet and touching Resident #2's feet. Nurse #4 pulled Resident #1 from the room.

A telephone interview was conducted on 4/3/23 at 11:00 AM. Nurse #4 indicated that on 3/25/23 she was not working with Resident #1, but his nurse asked for her assistance as she was not able to redirect him. When Nurse #4 arrived at Resident #2's room, Resident #1 was naked from the waist down, pulling things out of her closet and rubbing her feet and legs. Resident #1 had pulled the blankets off Resident #2. Resident #2 was crying out and yelling to get him out. The nurses decided to call the police. Resident #1 grabbed a plastic spoon with the handle sticking out and tried to get around her to Resident #2 in her bed. Nurse #4 revealed she pulled Resident #1 out of the room by the back of his t-shirt. When the police arrived, Resident #1 was resting calmly in bed after receiving anxiety medication. Nurse #4 indicated that Resident #1 frequently wandered in and out of other residents' rooms but could usually be redirected.

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During an interview on 4/3/23 at 11:40 AM, NA #1 revealed she heard yelling from Resident #2's room on 3/25/23 on evening shift and observed Nurse #4 pull Resident #1 out of the room by his t-shirt. She assisted Resident #1 back to him room. Resident #1 was calm and resting in bed when the police came. NA #1 called an off-duty nurse and texted the Director of Nursing (DON). NA #1 indicated that earlier that night, Resident #1 was in and out of other residents' rooms but was easily directed. NA #1 indicated all staff monitored him throughout the day.

A telephone interview was conducted on 4/4/23 at 12:10 PM, Nurse #5 revealed that prior to the incident on 3/25/23, Resident #1 was wandering in and out of residents' rooms on the 500 hall and going through their drawers. Resident #1 was escorted back to his room and was last seen lying in bed before he was found in Resident #2's room.

A Police Report dated 3/26/23 at 9:30 AM indicated an officer responded to an assault call at the facility involving Resident #1 and Resident #2.

The responding officer could not be reached for interview at multiple attempts.

Resident #1's Care Plan focus area for behaviors was updated on 3/26/23 to indicate indicated resident was wandering into another resident's room rummaging through other resident's items. No new interventions were put in place.

An observation was made on 4/3/23 at 10:10 AM of Resident #1 in his room, calmly sitting on his bed. He was dressed and groomed, and his NA

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had just assisted him with shaving. Resident #1 did not respond appropriately to questions and speech was difficult to understand. An observation was made later that day of Resident #1 in the DON's office eating a snack. He did not respond to the questioning.

During a telephone interview on 4/4/23 at 8:45 AM, the Mental Health Nurse Practitioner (NP) revealed she had been following Resident #1 since he was admitted. Resident #1 had expressed anxiety and agitation since admission and they had been working to adjust his antianxiety, antidepressants, and antipsychotic medications. The Mental Health NP revealed she was aware of behaviors such as wandering, aggression, and refusing medication. She indicated around 3/11/23, Resident #1 was refusing medication. The altercation on 3/11/23 was reported to her, and staff began mixing his antipsychotic medication into a drink and he would take it. She believed his behaviors improved after the medication change and he was doing well when she saw him on 3/24/23. She was not aware of the 3/25/23 altercation with another resident.

During an interview on 4/4/23 at 2:20 PM, the Nurse Practitioner revealed she was aware of Resident #1's behaviors of wandering and agitation and mental health services had been working with him. She was notified Resident #1 was sent to the emergency department several times for combativeness. The first instance was at the beginning of March. The Nurse Practitioner revealed that both Resident #6 and Resident #2 were very frail and could have been seriously injured by the interactions.

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F 600	Continued From page 10 During an interview on 4/6/23 at 10:30 AM, the DON revealed following the 3/11/23 incident, Resident #1's nurse called her to report finding him in Resident #6's room and appeared to be trying to kiss her. The DON reviewed the incident report when she returned to work but did not recall if it noted he was pulling her shirt and trying to kiss her. She did not conduct further staff or resident interviews. The DON indicated Resident #6 was frail and he could have injured her. At the time of the incident on 3/11/23, Resident #1 was on 15-minute checks due to an elopement. She was not aware of which NA was assigned to Resident #1 at the time of the incident. Resident #1 had previously been on 1:1 supervision but became agitated having someone with him all the time. The facility switched to 15-minute checks with someone assigned to monitor him throughout the day and sign off on a timesheet. She was unsure how he got into Resident #6 ' s room without the staff's knowledge. The DON revealed the intervention for the incident was to continuing monitoring Resident #1 with 15-minute checks. She was unsure why the 15-minute checks were discontinued on 3/12/23 and states she was not involved in the decision. She did not follow up with interviewing other staff or the NA assigned to Resident #1 at the time. The DON added, she was made aware of the 3/25/23 incident that night following the incident. She arrived the following day and spoke with the families of the residents. She believed the Administrator began an investigation on 3/26/23. The DON revealed staff monitored Resident #1 throughout the day and observed his location. They did not sign off checks at the time of the incident or following. The DON revealed the	F 600		

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facility did not have a process in place to monitor if interventions were effective.

During an interview on 4/6/23 at 11:30 AM, the Administrator revealed following the initial resident to resident altercation at the beginning of March 2023, the residents and family members were interviewed. Resident #1 was taken to the emergency department for evaluation. The Administrator indicated the other resident was alert and oriented and did not feel she was abused.

The Administrator revealed he was not aware Resident #1 appeared to be attempting to kiss Resident #6 during the 3/11/23 incident. No new interventions were put into place because the Administrator was not aware of the attempted kiss. The 15-minute checks for Resident #1 were discontinued due to not having exit seeking behaviors. He indicated the incident reports were reviewed in daily clinical meetings and an appropriate plan was put into place. Following the incident on 3/25/23, the residents were separated, and Resident #1 was calm. The facility began investigating the incident after Adult Protective Services visited the facility on 3/29/23. Staff statements were obtained. Alert and oriented residents were interviewed on if they experienced resident or staff abuse.

The Administrator was notified of IJ on 4/4/23 at 11:47 AM.

The facility provided the following immediate jeopardy removal plan:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as

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a result of the noncompliance:

Residents #6 and #2 are the most at risk for suffering adverse outcomes based on the facility's failure to protect them from physical abuse and intrusion into their personal space with attempts for inappropriate sexual interactions.

Resident #1 is the alleged abuser.

All residents are at risk for suffering physical and /or psychosocial harm as a result of the deficient practice.

Incidents were reported to the state on 4/4/23 by the Administrator.

Actions taken to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

On Tuesday, April 4, 2023 Resident #1 was relocated to a less populated hall to allow for more staff visibility from the Director of Nursing's (DON's) office, therapy suite, and nursing station.

This action will diminish wandering into other resident rooms. Should the wandering behavior present, the resident would have to cross the central corridor in the presence of the nursing station, DON's office, and therapy suite thus allowing for redirection and intervention.

On Tuesday, April 4, 2023 Resident #1 was placed on 1:1 monitoring by a facility staff member. The monitoring will continue 24/7 in order to ensure that all residents are free of adverse outcomes related to physical abuse and

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intrusion into their personal spaces. The resident was previously on 1:1 but was tapered to 15-minute checks when the incidents occurred. The monitoring will be increased to 24/7 the resident will be monitored at all times, including when the staff member takes breaks. A backup person will be assigned to the 1:1 caregiver.

A full staff mandatory meeting for all direct care staff, management staff, and contracted staff will be held on April 4, 2023 at 3:00 pm in the facility's dining room.

The facility Administrator and members of the Managing Director, VP Property, and Corporate Clinical Nurse Consultant will conduct the training session.

The DON will be responsible for maintaining the list of attendees and on-going survey education.

No staff member will be allowed to provide care to residents or otherwise resume normal job roles until they complete the training.

Training topics will include the following:
· Monitoring requirements for Resident # 1 to include 1:1 supervision at all times - with back up.
· Status of survey and interventions put in place.
· Training on the abuse policy and procedures to ensure full compliance with resident rights consistent with applicable state and federal law, specifically including the resident's right to be free of abuse and proper abuse reporting.
· Retraining of facility and contracted staff (therapy, dietary, and environmental services) to ensure awareness of:
-Abuse definitions
-Abuse reporting

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F 600	Continued From page 14 -Abuse allegation investigations -Facility Policies -Residents right to be free of abuse -Protection of all residents at the time of incident occurrence -Notification to Administrator and corporate team of all allegations The facility Administrator and Director of Nursing are responsible for the full implementation of the immediate jeopardy removal plan. The corporate operations, clinical, and compliance team will support the Administrator and Director of Nursing. Alleged immediate jeopardy removal date is 4/5/23. The credible allegation of IJ removal was validated by on-site verification on 4/6/23. Interviews conducted with staff revealed they had recent training on abuse that included types of abuse, reporting, and protecting residents involved. Education materials and staff signature sheets were reviewed. Resident #1 was observed with a 1:1 sitter. The facility's IJ removal date of 4/5/23 was validated.	F 600		
F 689 SS=K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		4/21/23

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F 689	Continued From page 15 by: Based on observation, staff interviews, Nurse Practitioner interview, and record review, the facility failed to provide the necessary supervision to prevent accidents for a resident (Resident #1) with severe cognitive impairment, poor safety awareness, and known behaviors that included exit seeking, wandering into other residents' rooms, and physical aggression for 1 of 1 resident reviewed for accidents. On 2/16/23 Resident #1 exited the facility unsupervised and without staff's knowledge and was found 1.7 miles away from the facility. This had a high likelihood of resulting in serious harm to Resident #1. On 3/11/23 Resident #1 was observed by Nurse #1 in Resident #6's room leaning over her bed with his hands pulling her shirt near her shoulder, their faces were inches apart, and Resident #1 had his lips pursed as though he was trying to kiss Resident #6 on her mouth. On 3/25/23 Resident #2 was heard calling out for help and when staff entered her room Resident #1 was observed naked from the waist down rubbing Resident #2's feet. These incidents initiated by Resident #1 had a high likelihood of causing serious physical injury to the victims. Resident #2 and Resident #6 did not have the cognitive ability to express an adverse outcome. A reasonable person expects to be protected from the presence of unwanted persons and advancements into their personal space in their home environment resulting in serious psychosocial harm with feelings such as intense fear, distress, and anxiety. Immediate Jeopardy (IJ) began on 2/16/23 when Resident #1 exited the facility unsupervised and without staff's knowledge. Immediate Jeopardy was removed on 4/5/23 when the facility provided	F 689	F 689 FREE of accident hazards, supervision, and devises Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and Resident # 1 is at risk for suffering adverse outcomes based on the facility□s failure to provide supervision of a resident with severe cognitive impairment, poor safety awareness, and behaviors including wandering and physically aggressive behaviors to prevent an unsupervised exit and resident to resident altercations. Resident #1 exited the facility with the assistance of another resident□s family member, who walked behind a desk and pressed the door release button. Residents #6, and #2 are the most at risk for suffering adverse outcomes based on the facility failure to supervise and prevent from accidents and hazards. All residents are at risk for suffering physical and / or psychosocial harm. Actions taken to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.	

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F 689	Continued From page 16 and implemented and acceptable credible allegation for IJ removal. The facility will remain out of compliance at a lower scope and severity level E (no actual harm with the potential for more than minimal harm that is not IJ) to ensure that education is completed, and monitoring systems put into place are effective. Findings included: 1a. Resident #1 was admitted to the facility on 2/1/23 with diagnoses that included dementia with behavioral disturbance and anxiety disorder. A nursing progress note dated 2/3/23 written by Nurse #6 indicated Resident #1 was anxious and going from room to room and to the front exit stating someone was coming to pick him up. A Care Plan dated 2/6/23 focused on elopement risk indicated Resident #1 was at risk for elopement related to disorientation to place, impaired safety awareness, and wandering behavior. Goals included Resident #1's safety will be maintained through the review period. Interventions included distract resident from wandering by offering diversions, identify pattern for wandering, monitor location, and provide structural activities. Resident #1's admission Minimum Data Set (MDS) dated 2/9/23 indicated he was severely cognitively impaired. He displayed physical behaviors directed at others and other behaviors not directed at others and wandered 4 to 6 days of the review period. Resident #1 was independent for walking and locomotion. A 72-hour wander risk assessment dated 2/7/23	F 689	A device cover (screamer cover) was placed over the release button on the day the unsupervised exit incident occurred 2-16-23. It is a device with a hinged lid that has to be opened to access the mag lock release. Opening the device results in a piercing alarm that alerts staff members audibly that the button has been accessed. In addition to the release button, there are keypads on all exit doors that allow for staff exit when the proper code is entered. The access code was changed on 2-16-23. Staff members were made aware of the access code change and staff members are the only persons that access the keypad. There is also a keypad for releasing the door lock that is on the wall to the immediate right of the door. On 2-16-23 the resident was placed on 1:1 supervision because prior to this date, he had never eloped before. Consultation with his attending physician / Nurse Practitioner resulted in a change in the resident s medication that stabilized his mood and behaviors. Education regarding not allowing residents to exit the building was provided to all staff members (employed and contracted housekeeping, dietary, environmental services and therapy contract staff). The facility does not have contracted	

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indicated Resident #1 was at high risk for wandering.

An Event Report dated 2/16/23 completed by the Administrator included the following Elopement timeline:
-start time 12:38 PM
-12:50 PM: The nurse noticed Resident #1 was not in his room. She proceeded to the front lobby area and resident was not in the facility. The administrator was notified.
-12:52 PM: Code Orange [announced over the speaker to indicate an unsupervised exit] was called.
-12:53 PM: Resident #1's Responsible Party, physician, and the police were notified.
-Staff members searched inside and outside the facility.
-1:17 PM: Resident #1 was found by a staff member (Receptionist).
The report indicated that the Administrator reviewed the security camera footage and observed a visitor opened the door and let Resident #1 walk out the front door.

During an interview on 4/4/23 at 10:00 AM, the Administrator indicated they did not have access to the security footage and corporate reviewed the footage and provided them with the information and timeline.

A police report dated 2/16/23 at 1:00 PM indicated the officer reported to the facility in reference to a missing person. The facility reported Resident #1 left the facility at 12:38 PM. As the officer was filling out the report, the Receptionist called the Administrator stating she had located Resident #1. Resident #1 was returned to the facility safe and unharmed.

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nursing staff.
The facility administrator conducted the training and letters to the families of current patients.
A letter was provided to all family members regarding the same. A letter was also added to the admission package to educate future residents and families about the importance of NOT allowing residents to exit the facility. This was done on 2/16/23.

On Tuesday, April 4, 2023 Resident # 1 was relocated to a less populated hall to allow for more staff visibility from the Director of Nursing□s (DON□s) office, therapy suite, and nursing station.

This action will diminish wandering into other resident rooms and protect all residents within the facility. Should the wandering behavior present, the resident would have to cross the central corridor in the presence of the nursing station, DON office, and therapy suite thus allowing for redirection and intervention and for supervision to prevent further occurrence.

On Tuesday, April 4, 2023 Resident #1 was placed on 1:1 monitoring by a facility staff member. The monitoring will continue 24 /7 in order to ensure that all residents are free of abuse and intrusion into their personal spaces. A back up staff member will be identified to cover breaks to ensure that the resident is monitored and supervised 24/7.

A full staff mandatory meeting for all direct

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The officer could not be reached for interview.

During an interview on 4/3/23 at 2:20 PM, Nurse #6 revealed that she arrived to Resident #1's room on 2/16/23 around 1:00 PM and noticed he was gone. She searched the facility and could not find him. She notified the Administrator, and he paged overhead to look for him. Management staff went out looking for him by car. Nurse #6 indicated that Resident #1 previously wandered around the facility and would walk to the front lobby. Nurse #6 indicated that the front door was locked and had to be unlocked by pushing a button behind the receptionist's desk.

A telephone interview was conducted on 4/4/23 at 9:30 AM. The Receptionist indicated that she was at lunch when Resident #1 left the facility. She revealed that Resident #1 was in the front lobby when she left for her lunch break. The staff members with offices off the lobby covered door duty while she was gone. The Receptionist indicated that she used a red button on the wall behind her desk to unlock the door for visitors, and a family member went behind her desk to push the button to get out of the front door. When she got back from her lunch break, staff was searching for Resident #1 by car. The Receptionist found Resident #1 in a parking lot of a credit union and he got into her car with her. Resident #1 was not alert and oriented and attempted to exit the car while she was driving. The Receptionist added that Resident #1 had to cross a very busy, dangerous road to get to his location.

A web search revealed the temperature for 2/16/23 at 12:35 PM was approximately 72

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care staff, management staff, and staff was held on April 4, 2023 at 3:00 pm in the facility□s dining room. The facility Administrator, Managing Director, VP of Property, and Corporate Nurse Consultant conducted the training session.

The DON will be responsible for maintaining the list of attendees and on-going survey education.

No staff member will be allowed to provide care to residents or otherwise resume normal job roles until they complete the training.

Training topics will include the following:

" Resident supervision to prevent accidents
" Redirection of patients with inappropriate behaviors including protection of resident□s rooms and personal spaces.
" The phrase PROTECT & REPORT was highlighted as the mantra for the educational session.
" Elopements
" Monitoring requirements for Resident # 1 (1:1 and 24/7 with breaks also covered).
" Immediate Jeopardy was discussed, defined, and the steps taken for IJ removal was reviewed.
" Retraining of facility and contracted staff (therapy, dietary, and environmental services) to ensure awareness of:
Resident Supervision

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F 689	Continued From page 19 degrees Fahrenheit (wunderground.com). Google maps indicated the distance between the facility and the parking lot where Resident #1 was found was 1.7 miles and was an estimated 33-minute walk. An observation was made 4/4/23 at 4:30 PM of the suspected route Resident #1 took down the street from the facility to the T-intersection. Speed limit was 45 miles per hour. The facility was off a two-lane road with very few sidewalks and large ditches on both sides of the road. The street came to a T-intersection with a four-lane road. Resident #1 had to cross the four-lane road. There were few sidewalks and many parking lots to cross to get to his final location. During an interview on 4/6/23 at 9:35 AM, the previous Director of Nursing (DON) indicated that Resident #1 left the facility after another family member allowed him out the front door. Prior to the incident Resident #1 would wander around the facility but she was not aware if he tried to get out the front door prior. The previous DON indicated that anyone with dementia that wanders was at risk for elopement and should be Care Planned for elopement risk. During an interview on 4/6/23 at 11:30 AM, the Administrator indicated that Resident #1 did not display exit seeking behaviors prior to leaving the building unsupervised on 2/16/23 around 12:38 PM. A visitor opened the door using the button behind the receptionist's desk. Following the incident, the facility provided letters to all families asking them not to let residents out the front door. The Administrator indicated he was not aware of exit seeking behavior prior to the elopement.	F 689	Elopements The facility Administrator and Director of Nursing will be responsible for full implementation of the facility plan of correction for the immediate jeopardy removal. They will be assisted by the corporate compliance, operations, and clinical team members. Date of Removal of Immediate Jeopardy: April 6, 2023 Since date of IJ removal DON and/or Administrator has completed 100% staff education on abuse policy, reporting, and elopements (risks) effective 4/10/2023. Social Worker and/or designee will conduct resident abuse interviews with 2 residents weekly x 4 weeks and then monthly x 2 months or until QAPI committee deems compliance. DON and/or Administrator will audit residents at risk for wandering x 4 weeks and then monthly x 2months or until QAPI committee deems compliance. Results of resident audits will be forwarded to the QAPI committee meeting monthly x 3 months or until deemed compliance. Any areas of concern will be corrected immediately.	

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1b. Resident #1 was admitted to the facility on 2/1/23 with diagnoses that included dementia with behavioral disturbance and anxiety disorder.

A Psychiatry Initial Consult dated 2/2/23 indicated staff reported Resident #1 was restless, anxious, agitated, and wandering. He was not sleeping. An as needed antianxiety was started.

His admission MDS dated 2/9/23 indicated he was severely cognitively impaired. He displayed physical behaviors directed at others 1 to 3 days of the review period and other behaviors not directed at others 4 to 6 days of the review period. Resident #1 was independent for walking and locomotion. He wandered 4 to 6 days of the review period.

A Care Plan dated 2/21/23 focused on behaviors related to Resident #1's episodes of combativeness towards staff, pacing, and going into other residents' rooms. Goals included Resident #1 will have fewer behaviors through the review period. Interventions included administer medications as ordered, anticipate resident's needs, and monitor behavioral episodes and attempt to find an underlying cause.

Record review indicated Resident #1 was on 15-minute checks 2/16/23 through 3/12/23 following an elopement. Staff signed a sheet indicating they were assigned to monitor Resident #1 at that time.

A telephone interview was conducted on 4/3/23 at 3:35 PM. Nurse #2 indicated that at the beginning of March 2023, Resident #1 was walking through

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a common are when another resident (from the assisted living section of the facility) reached her hand out to him. Resident #1 grabbed her wrist and twisted her arm behind her back. Staff directed him to let go and he hit her on the back of the head. The residents were separated. The other resident was "shaken", and the police were called. Nurse #2 added this was Resident #1's first physical interaction with another resident. Resident #1 had been on 1:1 supervision in the past for an elopement but was agitated having someone "following" him. The supervision was changed to 15-minute checks, and he did well with those.

An Incident Report dated 3/11/23 (a Saturday) written by Nurse #1 indicated that Resident #1 was found leaning over Resident #6 in her bed.

Resident #6's admission MDS dated 12/28/22 indicated she had moderate cognitive impairment.

During an interview on 4/3/23 at 3:20 PM, Nurse #1 indicated that on 3/11/23, she found Resident #1 in Resident #6 ' s room leaning over her bed with his hands pulling her shirt near the shoulder and their faces inches apart. When Nurse #1 got his attention, he looked at her then back to Resident #6, pulling her by the shirt with his lips pursed as though he was trying to kiss her mouth. Nurse #1 did not observe the residents' lips touching. A Nurse Aide (NA) was able to assist with getting Resident #1 out of the room. Resident #6 was crying, and Nurse #1 assisted her in calling her family member. Nurse #1 notified Resident #6 ' s family member and the Director of Nursing (DON) by telephone. The DON advised her to fill out an incident report.

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Nurse #1 believed she put the pulling of the shirt and attempted kiss in her incident report. That was the first time she had seen Resident #1 touching another resident, but he did wander in and out of residents' rooms. Nurse #1 indicated that staff monitored him throughout the day and intervened as needed. Resident #1 was usually able to be redirected. Nurse #1 was unsure if Resident #1 was on 15-minute checks at that time.

Record review indicated NA #5 had signed the 15-minute check off sheet for 3/11/23 from 11:00 AM to 1:00 PM (the time the incident occurred).

A telephone interview was conducted on 4/4/23 at 2:20 PM with NA #5 who was assigned to Resident #1 at the time of the 3/11/23 incident. NA #5 could not recall if she was assigned to Resident #1 at the time of the incident on 3/11/23. She indicated that Resident #1 was calm when she worked with him, and she had not observed behaviors directed at other residents. NA #5 revealed Resident #1 usually walked the halls with her and did not attempt to go in other residents' rooms.

Resident #6 was sleeping during attempts to interview on 4/3/23 at 10:00 AM and at 4/5/23 at 10:25 AM.

During an interview on 4/6/23 at 10:30 AM, the DON revealed following the 3/11/23 incident, Resident #1's nurse called her to report finding him in Resident #6's room and appeared to be trying to kiss her. The DON reviewed the incident report when she returned to work but did not recall if it noted he was pulling her shirt and trying

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F 689	Continued From page 23 to kiss her. She did not conduct further staff or resident interviews. The DON indicated Resident #6 was frail and he could have injured her. At the time of the incident on 3/11/23, Resident #1 was on 15-minute checks due to an elopement. She was not aware of which NA was assigned to Resident #1 at the time of the incident. The DON explained that Resident #1 had previously been on one to one (1:1) supervision but became agitated having someone with him all the time. The facility switched to 15-minute checks with someone assigned to monitor him throughout the day and sign off on a timesheet. She was unsure how he got into Resident #6 without staff's knowledge. The DON revealed the intervention for the incident was to continuing monitoring Resident #1 with 15-minute checks. She was unsure why the 15-minute checks were discontinued on 3/12/23 and states she was not involved in the decision. She did not follow up with interviewing other staff or the NA assigned to Resident #1 at the time. During an interview on 4/6/23 at 11:30 AM the Administrator revealed he was not aware Resident #1 appeared to be attempting to kiss Resident #6 on the 3/11/23 incident. No new interventions were put into place because the administrator was not aware of the attempted kiss. The 15-minute checks for Resident #1 were discontinued due to not having exit seeking behaviors. The Administrator revealed Resident #1 had a previous resident to resident incident with an assisted living resident earlier in March 2023. A progress note dated 3/25/23 (a Saturday) at 10:00 PM written by Nurse #3 indicated she	F 689		

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heard Resident #2 calling out from her room. When she entered, she observed Resident #1 naked from the waist down pulling the covers off Resident #2 and touching her feet. Resident #1 did not leave the room when prompted. The police were called.

A progress note dated 3/25/23 at 11:10 PM written by Nurse #4 for the same incident added that after the other nurse left the room, Resident #1 was pulling clothes from Resident #2's closet and touching her feet. Resident #1 grabbed a plastic spoon with the handle pointing outward and tried to get around Nurse #4 to Resident #2 in her bed. Nurse #4 pulled Resident #1 out of the room backwards by his t-shirt.

Resident #2's admission MDS dated 1/31/23 indicated she had moderate cognitive impairment.

A written statement from Nurse #4 revealed that on 3/25/23 around approximately 9:30 PM, Nurse #3 came to the nurse's station requesting assistance. She could hear loud voices on the 300 hall. Resident #1 was naked from the waist down "rummaging" through Resident #2's belongings. Resident #2 was crying out. Resident #1 was pulling off Resident #2's bedding and rubbing her feet. Resident #2 was getting more upset. Resident #1 was not able to be redirected to leave the room. Nurse #3 left to call the police. Resident #1 continued pulling things from the closet and touching Resident #2's feet. Nurse #4 pulled Resident #1 from the room.

A telephone interview was conducted on 4/3/23 at 11:00 AM. Nurse #4 indicated that on 3/25/23 she was not working with Resident #1, but his nurse

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asked for her assistance as she was not able to redirect him. When Nurse #4 arrived at Resident #2's room, Resident #1 was naked from the waist down, pulling things out of her closet and rubbing her feet and legs. Resident #1 had pulled the blankets off Resident #2. Resident #2 was crying out and yelling to get him out. The nurses decided to call the police. Resident #1 grabbed a plastic spoon with the handle sticking out and tried to get around her to Resident #2 in her bed. Nurse #4 revealed she pulled Resident #1 out of the room by the back of his t-shirt. When the police arrived, Resident #1 was resting calmly in bed after receiving anxiety medication. Nurse #4 indicated that Resident #1 frequently wandered in and out of other residents' rooms but could usually be redirected. Resident #1 was not on 15-minute checks at the time of the incident. Nurse #4 revealed she no longer worked at the facility.

A written statement from Nurse #3 indicated that on 3/25/23, she heard Resident #2 calling for help. Resident #1 was in her room naked from the waist down, pulling her bedding off and touching her feet. Nurse #3 attempted to get Resident #1 out of the room and was unsuccessful. Nurse #3 retrieved Nurse #4 for assistance. They were unsuccessful at getting Resident #1 out of the room. Nurse #3 left to call the police.

A telephone interview was conducted on 4/4/23 at 12:10 PM. Nurse #3 revealed that on 3/25/23 she heard someone calling out for help. She arrived at Resident #2's room and Resident #1 had removed Resident #2's bedding and had removed the air mattress control box from the foot of her bed. Resident #1 was not attempting

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to hit Resident #2 and gave the box to Nurse #3 when prompted. Resident #1 was naked from the waist down and was rubbing Resident #2's feet. Resident#2 was upset and was crying out. When Nurse #3 told Resident #1 to leave, he ignored her. Resident #1 was getting clothes out of Resident #2's closet and putting it on her bed. Nurse #3 revealed she left the room to call the police and Nurse #4 stayed with the residents. Resident #1 was calm in his room when the police arrived, so they did not intervene. Nurse #3 revealed that Resident #1 had wandering behaviors prior. Earlier that evening, he was found on another hall in another resident's room going through their belongings. Nurse #3 revealed that last time she had seen him he was resting in bed.

During an interview on 4/3/23 at 11:40 AM, NA #1 revealed she heard yelling from Resident #2's room and observed Nurse #4 pull Resident #1 out of the room by his t-shirt. She assisted Resident #1 back to his room. Resident #1 was calm and resting in bed when the police came. NA #1 texted the Director of Nursing (DON). NA #1 indicated that earlier that night, Resident #1 was in and out of other residents' rooms but was easily directed. NA #1 indicated all staff monitored him throughout the day.

A telephone interview was conducted on 4/4/23 at 12:10 PM, Nurse #5 revealed that prior to the incident on 3/25/23, Resident #1 was wandering in and out of residents' rooms and going through their drawers. Resident #1 was escorted back to his room and was last seen lying in bed before he was found in Resident #2's room.

A Police Report dated 3/26/23 at 9:30 AM

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F 689	Continued From page 27 indicated an officer responded to an assault call at the facility involving Resident #1 and Resident #2. The responding officer could not be reached for interview at multiple attempts. During an interview on 4/6/23 at 10:30 AM the DON indicated she was made aware of the 3/25/23 incident that following the incident. She arrived the following day and spoke with the families of the residents. The DON revealed staff monitored Resident #1 throughout the day and observed his location. They did not sign off checks at the time of the incident or following. The DON revealed the facility did not have a process in place to monitor if interventions were effective. During a telephone interview on 4/4/23 at 8:45 AM, the Mental Health Nurse Practitioner (NP) revealed she had been following Resident #1 since he was admitted. Resident #1 had expressed anxiety and agitation since admission and they had been working to adjust his antianxiety, antidepressants, and antipsychotic medications. The Mental Health NP revealed she was aware of behaviors such as wandering, aggression, and refusing medication. She was not aware of the 3/25/23 altercation with another resident. During an interview on 4/4/23 at 2:20 PM, the Nurse Practitioner revealed she was aware of Resident #1's behaviors of wandering and agitation and mental health services had been working with him. She was notified Resident #1 was sent to the emergency department several	F 689		

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times for combativeness. The first instance was at the beginning of March when he twisted the arm of another resident (a resident who resided in the assisted living section of the facility). The Nurse Practitioner revealed that both Resident #6 and Resident #2 were very frail and could have been seriously injured by the interactions. The NP was not aware of interventions regarding the altercations.

During an interview on 4/6/23 at 11:30 AM the Administrator he indicated the incident reports were reviewed in daily clinical meetings and an appropriate plan was put into place. Following the incident on 3/25/23, the residents were separated, and Resident #1 was calm. The facility began investigating the incident after Adult Protective Services visited the facility on 3/29/23. Staff statements were obtained. Alert and oriented residents were interviewed on if they experienced resident or staff abuse.

The Administrator was notified of immediate jeopardy on 4/4/23 at 11:47 AM.

The facility provided the following immediate jeopardy removal plan with an alleged removal date of 4/5/23:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

Resident # 1 is at risk for suffering adverse outcomes based on the facility's failure to provide supervision of a resident with severe cognitive

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impairment, poor safety awareness, and behaviors including wandering and physically aggressive behaviors to prevent an unsupervised exit and resident to resident altercations.

Resident #1 exited the facility with the assistance of another resident's family member, who walked behind a desk and pressed the door release button.

Residents #6 and #2 are the most at risk for suffering adverse outcomes based on the facility failure to supervise and prevent from accidents and hazards.

All residents are at risk for suffering physical and / or psychosocial harm.

Actions taken to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

A device cover (screamer cover) was placed over the release button on the day the unsupervised exit incident occurred - 2-16-23. It is a device with a hinged lid that has to be opened to access the mag lock release. Opening the device results in a piercing alarm that alerts staff members audibly that the button has been accessed.

In addition to the release button, there are keypads on all exit doors that allow for staff exit when the proper code is entered. The access code was changed on 2-16-23. Staff members were made aware of the access code change and staff members are the only persons that access the keypad. There is also a keypad for releasing the door lock that is on the wall to the

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F 689	Continued From page 30 immediate right of the door. On 2-16-23 the resident was placed on 1:1 supervision because prior to this date, he had never eloped before. Consultation with his Attending Physician / Nurse Practitioner resulted in a change in the resident ' s medication that stabilized his mood and behaviors. Education regarding not allowing residents to exit the building was provided to all staff members (employed and contracted housekeeping, dietary, environmental services and therapy contract staff). The facility does not have contracted nursing staff. The facility administrator conducted the training and letters to the families of current patients. A letter was provided to all family members regarding the same. A letter was also added to the admission package to educate future residents and families about the importance of NOT allowing residents to exit the facility. This was done on 2/16/23. On Tuesday, April 4, 2023 Resident # 1 was relocated to a less populated hall to allow for more staff visibility from the Director of Nursing's (DON's) office, therapy suite, and nursing station. This action will diminish wandering into other resident rooms and protect all residents within the facility. Should the wandering behavior present, the resident would have to cross the central corridor in the presence of the nursing station, DON office, and therapy suite thus allowing for	F 689		

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redirection and intervention and for supervision to prevent further occurrence.

On Tuesday, April 4, 2023 Resident #1 was placed on 1:1 monitoring by a facility staff member. The monitoring will continue 24 /7 in order to ensure that all residents are free of abuse and intrusion into their personal spaces. A back up staff member will be identified to cover breaks to ensure that the resident is monitored and supervised 24/7.

A full staff mandatory meeting for all direct care staff, management staff, and staff will be held on April 4, 2023 at 3:00 pm in the facility's dining room. The facility Administrator, Managing Director, Vice President (VP) of Property, and Corporate Nurse Consultant conducted the training session.

The DON will be responsible for maintaining the list of attendees and on-going survey education.

No staff member will be allowed to provide care to residents or otherwise resume normal job roles until they complete the training.

Training topics will include the following:
· Resident supervision to prevent accidents
· Redirection of patients with inappropriate behaviors including protection of resident ' s rooms and personal spaces.
· The phrase "PROTECT & REPORT" was highlighted as the mantra for the educational session.
· Elopements
· Monitoring requirements for Resident # 1 (1:1 and 24/7 with breaks also covered).

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F 689	Continued From page 32 · Immediate Jeopardy was discussed, defined, and the steps taken for IJ removal was reviewed. · Retraining of facility and contracted staff (therapy, dietary, and environmental services) to ensure awareness of: Resident Supervision Elopements The facility Administrator and Director of Nursing will be responsible for full implementation of the facility plan of correction for the immediate jeopardy removal. They will be assisted by the corporate compliance, operations, and clinical team members. The credible allegation of IJ removal was validated by on-site verification on 4/6/23. Interviews conducted with staff revealed they had recent training on elopements and resident monitoring. The admission packet letter on not allowing residents out the facility was reviewed. The device cover at the reception desk was observed and the receptionist was interviewed on use. Keypads were observed on all exit doors. Education materials and staff signature sheets were reviewed. Resident #1 was observed with a 1:1 sitter in his new room. The facility's IJ removal date of 4/5/23 was validated.	F 689		