STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185401	A. Building B. Wing	05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edmonson Nursing and Rehabilitation Center	813 South Main Street Brownsville, KY 42210

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44370 Based on observation, interview, record review, facility policy review, and review of the Centers for Medicare and Medicaid Services (CMS), Resident Assessment Instrument (RAI) Manual 3.0, it was determined the facility failed to develop and implement a comprehensive person-centered care plan that included measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs which had been identified in the comprehensive assessment. Review of Resident #4's Comprehensive Care Plan revealed the facility care planned the resident as at risk for elopement with interventions which included encouraging the resident's participation in activity preferences; allowing him/her to express his/her feelings, providing empathy and reassurance, and diverting the resident attention if he/she was near exits or doorways. On 09/06/2021 at approximately 6:32 PM, Resident #4 pulled the fire alarm on the 100 Hall on the East Unit, which caused the magnetic locking mechanism on the doors to automatically disengage allowing he resident to leave the facility without supervision of staff. The facility's staff followed its protocol for fire alarms, checked rooms discovering Resident #4 was not present on his/her unit. The facility's receptionist observed Resident #4 outside the front of the building walking towards a fast-food restaurant located there which was approximately three hundred and fifty (350) feet from the facility. Staff immediately went to assist Resident #4 to return to the facility, and staff helped the resident back into the building at 6:38 PM. The facility's failure to ensure the Comprehensive Care Plan was developed and implemented has caused or is likely to cause serious injury, harm impairment or death to a resident. Immediate Jeopardy (IJ) was identified on 04/27/2022 and determined to exist on 09/06/2021, at 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F656; and 42 CFR 483.25 Quality of Care, F689. Substandard Quality of Care (SQC) was identified at 42 CFR 483.25, F689 and determined to continue until 09/09/2021. The facility implemented corrective action which was completed prior to the State Survey Agency's investigation. Based on validation of the facility's corrective actions it was determined to be Past Jeopardy. The findings include: (continued on next page)

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.

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

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility policy titled, Person Centered Care Plan, revised 07/01/2019, revealed the facility would develop and implement a baseline person centered care plan within forty-eight (48) hours for each resident admitted which instructions needed to provide effective care and person centered care that met the professional standards for quality care, Per review, the Comprehensive Person Centered Care Plan was the individualized care plan developed within seven (7) days of the completion of the comprehensive assessment of each resident. Further review revealed the Comprehensive Care Plan was to include measurable objectives and timetables to meet a resident's medical, nursing, nutrition and mental and psychosocial needs identified during the comprehensive assessments. Review of Resident #4's closed record revealed the facility admitted the resident on 05/18/2021 with diagnoses which included Agitation, Delusional Disorder and Dementia without Behavioral Disturbance. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed Resident #4 as severely cognitively impaired as evidenced by the Brief Interview for Mental Status (BIMS) score of five (5). Continued review of the Admission MDS Assessment revealed the facility additionally assessed Resident #4 as independent with transfers and ambulation, and to have exhibited wandering for one (1) to three (3) days during the assessment period. Review of Resident #4's Comprehensive Care Plan, dated 05/24/2021, revealed the facility had care planned the resident to be at risk for elopement related to Dementia and Cognitive Loss. Review of the care plan revealed the goal was for Resident #4 to not attempt to leave the facility without an escort through the next review's target date of 09/15/2021. Continued review revealed interventions dated 05/24/2021, which included encouraging Resident #4 to participate in activities of his/her preference, for staff to encourage the resident's participation in activity preferences and allow him/her time to express his/her feelings. Continued review of the interventions revealed staff were to divert Resident #4's attention if he/she was near exits or doorways by giving the resident alternative objects or activities. Further review of the care plan revealed an intervention dated 08/25/2022 noting a Wander Guard monitoring device had been initiated. However, further care plan review revealed no documented evidence the facility had implemented interventions which addressed the need for additional supervision and monitoring required to keep the resident safe. Review of the facility's Certified Nursing Assistant (CNA) Kardex/Care Plan, dated 09/05/2021, revealed no documented evidence of interventions for the Wander Guard bracelet which had been initiated for Resident #4, nor of the supervision level required to keep the resident safe. Review of the facility's initial Elopement Evaluation, dated 05/18/2021, which part of the Nursing Admission Assessment, revealed the facility evaluated Resident #4 as not at risk for elopement. Review of the facility's 06/15/2021 Elopement Evaluation documented by the Center Nurse Executive (CNE) revealed Resident #4 had diagnoses which included Depression and Dementia. Continued review of the 06/15/2021 Elopement Evaluation revealed the CNE also noted Resident #4 to have expressed the desire to leave the facility through statements made regarding going home, and talking about going on a trip, and the resident attempted to pack his/her belongings. Further review of the 06/15/2021 Elopement Evaluation revealed the area that asked about a resident exhibiting one (1) or more emotional states or behavior which might result in exit seeking behavior, such as hovering near exits, restlessness or agitation had not been checked; however, none of the above had been checked on the document. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Continued review of the Elopement Evaluations for Resident #4, revealed an Evaluation dated 08/25/2021 completed by Licensed Practical Nurse (LPN) #6. Per review, LPN #6 documented Resident #4 had expressed the desire to leave the facility to go home and talked about going on a trip. Review revealed the resident had also attempted to pack his/her personal belongings and had hovered near the facility's exits. Review of Resident #4's General Progress Note, dated 08/25/2021 at 5:01 PM, completed by LPN #6, revealed the resident had been hovering near the facility's front door and talked about going home one way or another. Per review of the 08/25/2021 Note, a Wander Guard bracelet had been initiated and placed on Resident #4. Further review of the Note revealed however, no documented evidence of interventions having been implemented regarding the necessary monitoring and supervision and monitoring of Resident #4 to assist further with preventing the resident from eloping from the facility. Review of the General Nursing Note, dated 09/05/2021 at 5:56 PM documented by LPN #3 revealed Resident #4 had been wandering throughout the building looking for a way out and the resident wanted to go home. Continued review of the 09/25/2021 Note revealed Resident #4 had a Wander Guard bracelet in place to right ankle, and the resident got agitated when staff provided redirection. Further review revealed Resident #4 had requested staff call the cops to come get him/her. In addition, review further revealed Resident #4 had talked to his/her son which had not improved his/her agitation or wandering, checking all doors. Interview on 04/25/2022 at 10:54 AM, with Certified Nursing Assistant (CNA) # 9, revealed Resident #4 had always walked around and been on the go. CNA #9 stated Resident #4 had a Wander Guard bracelet on and staff knew to keep an eye on him/her. Continued interview revealed staff often sat and talked with Resident #4, and took turns sitting with him/her to keep the resident busy. Per CNA #9, the facility's CNE, Center Executive Director (CED), and the Assistant Director of Nursing (ADON) also sat with Resident #4 to keep the resident occupied. Further interview revealed the facility's CNA Care Plan/Kardex was a reference tool for CNAs to know the care they needed to provide for residents. She further revealed however, she could not recall what Resident #4's Kardex had said. Interview on 05/03/2022 at 4:05 PM, with Certified Nurse Assistant (CNA) #11, revealed she remembered Resident #4 wandering around the facility. She revealed Resident #4 had worn a Wander Guard, and his/her name had been in the facility's elopement book in order for staff to know to keep an eye on the resident. Per CNA #11, the facility's CNA Care Plan/Kardex was a reference tool for CNAs to assist with providing care of the residents. Further interview revealed she did not recall any interventions for Resident #4 related to supervision needs/levels or for monitoring the resident having been in place prior to the elopement. She further revealed she thought supervision needs for wandering residents would have been located on the Kardex though. Interview on 05/03/2022 at 4:18 PM, with CNA #12 revealed Resident #4 wandered around the facility; however, she had never seen Resident #4 trying to exit seek. She revealed Resident #4 had worn a Wander Guard and had been at risk for elopement so staff kept an eye on the resident when he/she had wandered. Further interview revealed a wandering resident should have been on increased supervision and that should have been on the resident's Kardex. She further revealed she could not remember what Resident #4's Kardex said though regarding supervision (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 05/03/2022 at 2:36 PM, with the Business Office Manager (BOM) and former Activity Director, revealed the facility had provided Resident #4 with an activity apron to keep him/her busy, but the resident seldom used it. She revealed the activity and nursing staff fixed Resident #4's hair by rolling or curling it. She revealed Resident #4 had nails done often more than weekly. She revealed Resident #4 liked sitting out on the veranda and staff would sit with him/her. The BOM revealed the CED, CNE, ADON and other staff would sit with her on most days. Interview on 05/03/2022 at 2:10 PM, with MDS Nurse #2 revealed MDS staff were responsible for developing and revising residents' care plans on admission, quarterly, annually, and with a significant change in the resident(s). Per interview, the staff nurses updated residents' care plans if there were changes in a resident's status or condition between the MDS Assessment intervals. She revealed all Physician's orders were reviewed daily and residents' care plans revised if needed. Continued interview revealed there had been an at risk for elopement care plan in place for Resident #4; however, no interventions were in place on the care plan to address supervision and monitoring of the resident even though he/she wandered constantly daily and had made remarks about going home. MDS Nurse #2 further stated Resident #4 should have had those types of interventions in place. Interview on 05/03/2022 at 2:21 PM, with the Center Nurse Executive (CNE) revealed Resident #4 wandered the facility, but was easily redirected by staff. He stated he felt Resident #4's care plan had contained the appropriate interventions prior to the elopement as the resident had not tried to actually exit the building. Interview on 05/03/2022 at 2:35 PM, with the Center Executive Director (CED) revealed Resident #4's risk for elopement care plan supervision level had been adequate prior to the resident's elopement from the facility. The CED stated the supervision level was adequate as the the facility had no knowledge of Resident #4 having ever attempted to elope before. The facility alleged the following was implemented to remove the Immediate Jeopardy and correct the deficiency on 09/09/2021: 1. Resident #4 was returned to the facility on [DATE] and was assessed for injuries. No injuries were identified, and the Physician and responsible party were notified. 2. A body audit was completed on 09/06/2021 by a licensed nurse with no injuries noted. The Physician and responsible party were notified by a licensed nurse on 09/06/2021 with new orders received. 3. An assessment was completed of Resident #4 by a licensed nurse which included vital signs which had been in the usual range for the resident. Resident #4 was noted by a licensed nurse to move all extremities without difficulty and without complaints of pain or discomfort. 4. Resident #4's elopement assessment was reviewed and updated on 09/07/2021 by the Center Nurse Executive. The Wander Guard on the resident had been checked to ensure it was working properly by the licensed nurse on 09/07/2021. 5. Social Services, the CNE or CED interviewed Resident #4 and the resident stated he/she just wanted to go home to see his/her dog. Resident #4 had a BIMS score of five (5). (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. Resident #4's care plan/Kardex was updated on 09/06/2021 by the CNE to include review of elopement evaluation and Wander Guard. 7. RN and LPN Charge Nurses immediately completed a visual validation of the facility's resident census check. All residents, 69 of 69 were present inside the facility. This was completed on 09/06/2021 at 7:20 PM. 8. Maintenance director checked all doors to ensure they were functioning correctly. 9. Staff interviews regarding the elopement were conducted by the CNE and or CED with staff who had been working at the time of the event on 09/06/2021. 10. Record review of elopement assessments, care plans, and Kardex's was conducted on all residents residing in the facility. 69 of 69 facility residents' records were reviewed starting 09/07/2021 and completed on 09/07/2021 by the CNE, Unit Managers, RN and/or LPN to identify any new elopement risks and determine whether the care plan and Kardex reflected the current needs of the resident. The elopement risk evaluations for all at risk residents, care plans and Kardex's were reviewed and updated by the licensed nurse. 11. Staff re-education was immediately initiated by the CED, CNE, NPE, Unit Managers and Licensed Nurses beginning on 09/07/2021. All remaining staff members and newly hired staff members completed education prior to reporting for their next assigned shifts. The re-education for all staff included: (A.) Review of Center Policies on elopement prevention and management to include exiting the facility to determine that a resident was not outside the facility and including securing the fire doors when the alarm was sounding. (B.) Supervision needs of residents assessed as at risk for elopement. (C.) Review of the facility policy for following each resident's person-centered care plan or Kardex regarding residents at risk for elopement. (D.) All employees including contract employees were to complete a posttest to validate their learning. A passing score of 100% was required. Staff and contract employees not available were to be provided the re-education by the CNE, Resource Nurse, Unit Managers and/or Licensed Nurses, and complete a posttest upon the day of their return to work before providing care. (E.) All newly hired employees and contract employees were to have the elopement education by the CNE, HR/Payroll, Resource Nurse, Unit Managers and or Licensed Nurses and complete a posttest during orientation. 12. Elopement drills were completed over three (3) different shifts from 09/07/2021 through 09/08/2021, with no concerns identified. Elopement Drills were to be conducted daily for two (2) weeks including weekends, then three (3) times per week for two (2) weeks then weekly for eight (8) weeks, then every other week for eight (8) weeks then monthly for one (1) month then as determined by the facility's QAPI Committee. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	13. Fire Drills were completed over three (3) shifts on 09/07/2021 with no concerns identified. Fire drills were to be conducted daily for two (2) weeks including weekends, then three (3) times per week for two (2) weeks, then weekly for eight (8) weeks, then every other week for eight (8) weeks then monthly for one (1) month then as determined by the QAPI Committee. 14. Interviews of five (5) random staff members daily regarding interventions on care plan for residents who were at risk of elopement were to be completed by the CNE, CED, Charge Nurses and Unit Managers, daily for two (2) weeks including weekends, then three (3) times per week for two (2) weeks, then weekly for eight (8) weeks, then every other week for eight (8) weeks then monthly for one (1) month then as determined by the QAPI Committee. 15. Visual Observation Audits were to be conducted by the CNE, CED Department Managers to determine if staff were following the residents' plan of care to ensure residents who were at risk for elopement were not allowed to exit the facility without supervision. The Visual Observation Audits were to be conducted daily for two (2) weeks including weekends, then three (3) times per week for two (2) weeks, then weekly for eight (8) weeks, then every other week for eight (8) weeks then monthly for one (1) month then as determined by the QAPI Committee. 16. An Ad Hoc QAPI Committee meeting was held on 09/07/2021 with the Medical Director, for recommendations in developing the action plan including audits, re-education, and compliance monitors for residents at risk for elopement. Results of the elopement drills were to be reviewed daily by the Administrator and CNE for follow up with staff. 17. Elopement drills were to be reviewed at the QAPI Committee meetings monthly for six (6) months for any additional follow up and or in servicing until the issues were resolved and ongoing thereafter as determined by the QAPI Committee. The QAPI Committee members might include Administrator, DON, ADON, Admissions and Marketing Coordinator, Social Services Director, Reimbursement Manager, Maintenance Director, Nurse Practice Educator, and Nutrition Services Director. The State Agency verified the facility's action plan had been implemented and the deficiency was corrected on 09/09/2021: 1. Review of the facility's investigation, timeline of events and Resident #4's every fifteen (15) minute check log initiated 09/06/2021 at 6:45 PM, confirmed staff assisted the resident back into the facility. Review of a Change in Condition (CIC) Evaluation dated 09/06/2021 revealed Resident #4 was assessed by the Center Nurse Executive (CNE) on 09/06/2021. Continued review of the CIC revealed the responsible party had been made aware of the incident on 09/06/2021 at 6:49 PM, and the APRN was made aware at 6:55 PM on that date. 2. Review of a Skin Check and a CIC Evaluation dated 09/06/2021 at 7:54 PM revealed LPN #5 and the CNE completed a full body audit of Resident #4. The resident's responsible party was made aware on 09/06/2021 at 6:49 PM and the APRN was made aware at 6:55 PM. 3. Review of the CIC dated 09/06/2021 at 7:54 PM revealed LPN #5 and the CNE completed a head-to-toe assessment of Resident #4, and the resident was found to have no injuries, and voiced no pain or concerns. The resident's vital signs were obtained and were within normal limits for him/her. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. Review of Resident #4's Elopement Risk Evaluation dated 09/07/2021 and completed by the CNE, revealed the resident had been assessed as at risk for elopement. Review of the Progress Note dated 09/06/2021 at 7:00 PM and signed by the CNE, revealed Resident #4's Wander Guard bracelet had been checked and determined to be functioning properly when the resident was returned to the facility. 5. Review of the General Progress Note dated 09/07/2021 at 2:40 PM, revealed an interview with Resident #4 had been completed by Social Services. Interview with the Social Services staff person on 05/03/2022 at 2:40 PM, revealed she interviewed Resident #4 about exiting the facility and the resident told her he/she had recently lost his/her spouse and son, and the resident was feeling down. She revealed Resident #4 wanted to see his/her dog and was going to walk home. 6. Review of Resident #4's elopement care plan dated 05/24/2021 and the CNA Kardex dated 09/13/2021, revealed the care plan and the CNA Kardex were revised on 09/06/2021 by the CNE to include the following interventions: 1:1 monitoring as needed; visual checks of the resident every fifteen (15) minutes; compassionate care visits as needed; and activities to provide an animated puppy to comfort resident. 7. Review of the facility's Midnight Census Report dated 09/06/2021 at 7:00 PM, confirmed a head count of all facility residents had been conducted by licensed staff and the CNE. Review revealed the head count determined all 69 of 69 facility residents were present. 8. Review of the facility's Daily Check Sheet confirmed door checks had been completed by the Maintenance Director on 09/06/2021 through 09/10/2021. Interview with the Maintenance Director on 04/20/2022 at 2:07 PM, revealed he completed daily door checks beginning on 09/06/2021 through 09/10/2021 with no issues identified. 9. Review of the facility investigation revealed witness statements were obtained from staff who had been working when Resident #4 exited the facility on 09/06/2021. 10. Review of the Assessment History for Elopement revealed the Elopement Assessments were completed for 69 of 69 facility residents on 09/07/2021 by the CNE with no new elopement risks identified. 11. Review of the facility's education rosters revealed education had been provided for the facility staff by the CNE regarding the following facility policies and procedures: Elopement Prevention and Management; Supervision needs for residents at risk for elopement; and Person-Centered Care Plan. Review of the facility education post-tests, dated 09/07/2021 through 09/09/2021, revealed education had been provided for facility staff with a posttest completed and this was ongoing with new hires and or contracted staff. Interview on 05/03/2022: at 1:20 PM with LPN #3; LPN #9 at 1:25 PM; with CNA #3 at 1:30 PM; CNA #11 at 4:05 PM; and CNA #12 at 4:18 PM revealed they had all received education provided by the NPE and CNE on what to do if there was a missing resident, on updating residents' care plans/Kardexes, on elopement drills, and fire drills. The staff interviewed revealed all had completed a posttest after receiving the education. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	17. Review of additional QAPI meeting rosters for meetings held on 10/20/2021, 11/17/2021, 12/15/2021, 01/27/2022, 02/15/2022 and 03/16/2022 revealed elopement drills were reviewed. Continued review revealed the QAPI Committee members present for the various monthly meetings included all or some of the following staff: the Administrator, DON, Assistant DON (ADON), Admissions and Marketing Coordinator, Social Services Director, Reimbursement Manager, Maintenance Director, NPE, and Nutrition Services Director. In addition, review revealed the Medical Director had been present for all of the QAPI Committee meetings.

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Edmonson Nursing and Rehabilitation Center	813 South Main Street Brownsville, KY 42210

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44370 Based on interview, record review, review of facility policy and investigation documentation, it was determined the facility failed to ensure each resident received adequate supervision and monitoring to prevent elopement for one (1) of three (3) sampled residents (Resident #4). On 09/06/2021 at approximately 6:32 PM, Resident #4 activated the pull fire alarm on the 100 Hall on the East Unit, causing the magnetic locking mechanism on the facility doors to automatically disengage. This allowed Resident #4 to exit the facility without the staff's knowledge and supervision. Per the facility's protocol, facility staff proceeded to check all rooms and closed doors, discovering Resident #4 was not on his/her unit. The facility's receptionist observed Resident #4 outside the building, walking towards a fast-food restaurant located approximately three hundred and fifty (350) feet from the front of the facility. Staff were immediately deployed to retrieve Resident #4 and returned him/her to the facility at 6:38 PM. The facility's failure to have an effective system in place to ensure residents were supervised and monitored to prevent accidents has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on 04/27/2022 and determined to exist on 09/06/2021, at 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F656; and 42 CFR 483.25 Quality of Care, F689. Substandard Quality of Care (SQC) was identified at 42 CFR 483.25, F689 and determined to continue until 09/09/2021. The facility implemented corrective action which was completed prior to the State Survey Agency's investigation. Based on validation of the facility's corrective actions it was determined to be Past Jeopardy. The findings include: Review of facility policy titled, Elopement of Patient, revised 02/28/2021, revealed residents were to be evaluated/assessed for elopement risk upon admission, re-admission, quarterly and with a change in condition as part of the clinical assessment process, and as defined by the Resident Assessment Instrument (RAI) manual criteria utilizing the nursing assessment, social services assessment, and other disciplinary assessments. Per review, elopement was defined as occurring when a resident left the premises without authorization. Continued review revealed those residents determined to be at risk were to receive appropriate interventions to reduce risk and minimize injury. Further review revealed for residents identified as at risk, an interdisciplinary elopement prevention resident-centered care plan was to be developed with the resident's participation and his/her representative as applicable (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Closed record review revealed Resident #4 was admitted to the facility on [DATE] with diagnoses that included Unspecified Dementia without Behavioral Disturbance, Delusional Disorder, and Agitation. Review of Resident #4's initial Elopement Evaluation, embedded in the Nursing Admission Assessment, dated 05/18/2021, revealed the facility had assessed the resident as not at risk for elopement. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed Resident #4 to have exhibited wandering one (1) to three (3) days during the assessment period, and was independent with transfers and ambulation. Continued review of the MDS Assessment revealed the facility assessed Resident #4 to have a Brief Interview for Mental Status (BIMS) Score of five (5) indicating severe cognitive impairment. Review of the facility's Elopement Evaluation dated 06/15/2021, completed by the Center Nurse Executive (CNE) revealed it was the facility's risk assessment document utilized to determine a resident's risk for elopement. Resident #4 was independent with ambulation, had diagnoses of Dementia and Depression and had expressed the desire to leave, e.g., going home, talked about going on a trip, and attempted to pack his/her belongings. Further review revealed the areas stating exhibiting one (1) or more emotional states or behavior that might result in exit seeking behavior, i.e. hovering near exits, restlessness or agitation had not been checked on the Evaluation; however, the none of the above area had been checked. Review of the Elopement Evaluation, dated 08/25/2021 and completed by Licensed Practical Nurse (LPN) #6, revealed Resident #4 had expressed the desire to leave the facility, e.g., going home, talked about going on a trip, attempted to pack his/her belongings and had been hovering near exits. Review of a General Progress Note completed by LPN #6, on 08/25/2021 at 5:01 PM, revealed the nurse documented Resident #4 had been hovering near the front door and talked about going home one way or another, and orders received for Wander Guard placement received. Further review of the General Progress Note revealed a Wander Guard bracelet was placed on Resident #4's left ankle; however, there was no documented evidence of other interventions implemented related to the supervision and monitoring of the resident to prevent elopement. Review of Resident #4's Comprehensive Care Plan dated 05/24/2021, revealed the facility had care planned the resident as at risk for elopement related to Cognitive Loss/ Dementia. Per review, the care plan goal for Resident #4 was the resident would not attempt to leave the facility without an escort through the next review, with a target date of 09/15/2021. Continued review of the risk for elopement care plan revealed the interventions in place as of 05/24/2021 included: for staff to encourage the resident's participation in activity preferences; allow time for expression of his/her feelings; provide empathy, encouragement, and reassurance; divert the resident by giving alternative objects or activities; and as appropriate re-direct the resident if he/she was near exits or doorways. Additionally, review of the care plan revealed on 08/25/2021 a Wander Guard monitoring device had been initiated. Further review revalued however, no documented evidence of interventions to address the need for supervision and monitoring of Resident #4 regarding his/her elopement risk; nor, was there documented evidence of the supervision level required to keep the resident safe. Review of the Certified Nursing Assistant (CNA) Kardex/Care Plan (a facility document utilized to notify the CNAs of the care their residents' required) dated 09/05/2021 revealed no documented evidence of interventions related to the supervision needs of Resident #4 or of the Wander Guard bracelet placed on the resident's ankle. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the General Nursing Note dated 09/05/2021 at 5:56 PM for Resident #4 signed by Licensed Practical Nurse (LPN) # 3 revealed Resident wandering throughout the building looking for a way out, wants to go home. Continued review revealed LPN #3 documented the resident ' s wander guard was in place to the right of his/her ankle. She further noted the resident got agitated with redirection, requesting for staff to call the cops to come get him/her. Additionally, the review revealed LPN #3 documented Resident #4 had been checking all the doors. Review of the facility's Timeline/Investigation dated 09/06/2021, revealed Resident #4 eloped on 09/06/2021 at approximately 6:32 PM after activating a fire alarm pull station on the 100 Hall on the East Unit. Review revealed Resident #4 was witnessed by staff within minutes of pulling the alarm ambulating in the parking lot. Continued review revealed staff paged the facility's code red as per policy to 100 Hall and staff initiated searching for the fire by checking all rooms and outside the therapy door with no concerns. Per review, at 6:34 PM, staff noted Resident #4 was not in the vicinity, and between 6:34 PM and 6:36 PM, staff began searching for the resident. Review revealed at 6:36 PM, the front desk staff notified nursing of having observed Resident #4 in the parking lot walking towards a restaurant located in front of the facility and staff were immediately deployed to retrieve the resident. Further review revealed at 6:37 PM the Center Nurse Executive (CNE) was notified, and at 6:38 PM, Resident #4 was put in a staff member's car and returned to the facility. The Timeline/Investigation documentation revealed at 6:43 PM, Resident #4 exited the staff member's car and re-entered the facility, and his/her Wander Guard bracelet was tested and determined to be functioning properly. Review further revealed a nurse assessed Resident #4 at 6:45 PM, who had been wearing long sleeves, pants, and shoes at the time of elopement, with no injuries noted. In addition, review revealed at 6:49 PM, the resident's family was made aware of his/her elopement, with the Advanced Practice Registered Nurse (APRN) notified at 6:55 PM. The review of the facility's Timeline/Investigation documentation revealed the facility's root cause analysis determined Resident #4 exited the facility after activating the pull fire alarm on the 100 Hall of the East Unit, which rendered the resident's Wander Guard bracelet inactive causing it not to alarm. Review of the Weather History for the facility's location on 09/06/2021, revealed the temperature had been eighty-two (82) degrees Fahrenheit at 5:56 PM and seventy-seven (77) degrees Fahrenheit at 6:56 PM, with fair conditions. On 04/20/2022 at 1:15 PM, the State Survey Agency (SSA) Representative walked from the facility to the restaurant parking lot where Resident #4 had been located on 09/06/2021. The SSA Representative determined the distance from the facility to the restaurant where Resident #4 was located was approximately three hundred and fifty (350) feet. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Licensed Practical Nurse (LPN) #1 on 04/20/2022 at 10:38 AM, revealed Resident #4 wandered and paced the facility every day. She revealed Resident #4 had anxiety and agitation, was constantly up doing something, and often looked out the door making comments about going home, checking on his/her family and getting home to check on the kids. Continued interview revealed Resident #4 had a Wander Guard bracelet on which had been checked every shift. According to LPN #1, she had never seen Resident #4 make any attempts to get out of the facility before 09/06/2021. She revealed on 09/06/2021 her shift was ending when the fire alarm sounded so she assisted with the code and started checking rooms and closing doors on 100 Hall. Per LPN #1, there had been no fire identified on the unit; however, she and Certified Nursing Assistant (CNA) #2 noticed that they had not seen Resident #4 and informed LPN #5. Further interview revealed staff began searching the facility for Resident #4 and had not located the resident. LPN #1 further stated when staff returned to the facility's lobby area the receptionist told them Resident #4 had been found walking towards the restaurant and other staff were bringing him/her back to the facility. Interview with Certified Nursing Assistant (CNA) #2 on 04/20/2022 at 11:02 AM, revealed she was working on the facility's East Unit on 09/06/2021 when Resident #4 exited the building. She revealed she last saw Resident #4 when they were passing the residents' supper meal trays. CNA #2 stated she was in a resident's room making a bed when the fire alarm sounded and was paged for the 100 Hall. Per CNA #2, staff checked the rooms and Resident #4 was not located on the unit. Further interview revealed she informed Licensed Practical Nurse (LPN) #5 of that information, and then she and LPN #1 started a room-to-room search looking for the resident. In addition, she stated after searching the East Unit she was told Resident #4 was outside the building, walking to the restaurant in front of the facility and LPN#2 and LPN #5 had gone to get him/her. Interview with Licensed Practical Nurse (LPN) #2, on 04/20/2022 at 11:48 AM, revealed Resident #4 had wandered all the time and was all over the building. She revealed in the beginning when first admitted Resident #4 would pack up his/her belongings daily and would want to go home. Continued interview revealed she was working 09/06/2021 on the facility's [NAME] Unit when the fire alarm sounded. LPN #2 stated all the residents on the [NAME] Unit had been accounted for and she had gone to the East Unit to assist. According to the LPN, she entered the lobby area and heard the receptionist say there the resident is. Further interview revealed Resident #4 had been walking to the restaurant in front of the facility, and she and LPN #5 ran out the door after the resident. In addition, she revealed Resident #4 was in the parking lot of the restaurant and had been upset because he/she thought they could make it home. Interview with LPN #3 on 04/21/2022 at 2:54 PM, revealed she had worked on 09/06/2021; however, had not been working at the time of the incident. Per LPN #3, Resident #4 had wandered daily, and often made comments about going home, but she had never seen the resident go to a door and try to get out it. Further interview revealed Resident #4 also would pack up his/her belongings daily; however, that had gotten better. She additionally stated the day after the elopement Resident #4 had seemed fine like nothing had ever happened. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with LPN #5 on 04/22/2022 at 8:30 AM, revealed she was familiar with Resident #4's wandering throughout the facility. She revealed Resident #4 often made statements about going home to get his/her dog, and frequently looked out the door, but she has never seen the resident try to push on the doors in attempts to exit the facility. Continued interview revealed LPN #5 had been working on 09/06/2021 when Resident #4 pulled the fire alarm and exited the facility at approximately 6:30 PM. Per LPN #5, she had just come on her shift at 6:00 PM and was standing at the medication cart, and Resident #4 had been sitting in a chair talking about wanting the state police called to bring his/her dog. She stated she had been preparing Resident #4's medications when the telephone rang, and she stepped away from the medication cart to answer it. According to the LPN, the next thing she knew the fire alarm was going off, and she checked the panel and followed the facility's protocol. LPN #5 revealed staff checked the rooms and realized Resident #4 was no longer on the unit. Interview revealed the receptionist came and told staff Resident #4 was walking to the restaurant in front of the facility. Further interview revealed LPN #2 and LPN #5 immediately ran out the door to go get Resident #4 and return him/her to the facility. She revealed when they reached Resident #4 he/she had been weak so she (LPN #5) had called a staff member to come and pick all of them up in his/her vehicle. In addition, she stated she assessed Resident #4 upon return to the facility and had observed no injuries. She further stated she had notified the CNE, Resident #4's family and the Physician, and the resident had been placed one to one (1:1) supervision by staff until his/her family arrived. Interview further revealed Resident #4's family left the resident had been in bed, and he/she was placed on every fifteen (15) minute checks. Interview with LPN #6 on 04/22/2022 at 3:48 PM, revealed Resident #4 was not someone who liked to sit still. She stated Resident #4 had always been up doing something and enjoyed looking out the door. Per LPN #6, she had never seen Resident #4 attempt to exit the facility; however, on 08/25/2021 she observed the resident hovering at the door, talking about going home and wondering where his/her son was. She revealed she informed the APRN and CNE and received an order for a Wander Guard bracelet to be placed on the resident. Further interview revealed she completed an elopement assessment and updated Resident #4's care plan with the Wander Guard placement; however, could not recall if she included any interventions related to supervision of the resident. She further revealed all staff were aware of residents who were at risk of elopement, and they all knew to keep an eye on those residents. Interview with CNA #6 on 04/25/2022 at 9:45 AM, revealed she recalled Resident #4 often walked around on the [NAME] Unit. She revealed Resident #4 had a Wander Guard bracelet in place, and that's how staff knew to keep an eye on him/her. Further interview revealed the Wander Guard bracelet might have been on the Kardex; however, would definitely have been in the elopement binder at the nurse's station. In addition, she further revealed Resident #4 had always been easily redirected, but sometimes needed assistance to return to the East Unit. Interview with CNA #5 on 04/25/2022 at 10:01 AM, revealed she remembered Resident #4 wandered but had never seen the resident doing any exit seeking. CNA #5 stated Resident #4 had made statements about going home or missing his/her dog, and she tried to distract or redirect the resident at those times by giving him/her snacks or just sitting and talking to him/her. Further interview revealed Resident #4 had a Wander Guard in place, and staff knew to keep an eye out for residents with Wander Guard bracelets on. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the Center Nurse Executive (CNE) on 04/20/2022 at 2:00 PM, revealed he had received a call from LPN #5 on 09/06/2021, who told him Resident #4 had pulled the fire alarm and went out the door on 100 Hall. He revealed LPN #5 had informed him Resident #4 had gotten to the parking lot of the restaurant in front of the facility and LPN #2 and LPN #5 had ran to get him/her. Per the CNE, he immediately went to the facility, where LPN #5 had assessed Resident #4 with no concerns identified, after his/her return to the facility. Continued interview revealed he assessed Resident #4 and completed a skin assessment, and had completed a change in condition/Situation, Behavior, and Assessment-Recommendation (SBAR). Per the CNE, staff had made the Advanced Practical Registered Nurse (APRN), Physician and resident's family aware of the event. The CNE further revealed after Resident #4 eloped, the facility ensured there was 1:1 supervision with family or a staff member; and then every fifteen (15) minute checks of the resident had been initiated. Additional interview revealed the CNE was aware Resident #4 had wandered but had been easily redirected. He also stated he had not been aware of Resident #4 had a history of elopement prior to admission. Interview with the Center Executive Director (CED) on 04/20/2022 at 1:28 PM, revealed he had received a notification from the fire alarm company via a phone call that a facility fire alarm had been triggered. He revealed he called the facility immediately and the receptionist informed him that a resident had gotten outside. Per the CED, he immediately went to the facility and initiated an action plan after the incident occurred. Continued interview revealed there had been an ad-hoc Quality Assurance Performance Improvement (QAPI) meeting with the staff and Medical Director on 09/07/2021. He stated no other residents had attempted elopement and the facility had placed a covering on the door to distract a resident from what was going on outside. The CED revealed he and the CNE initiated an elopement investigation on the day of the elopement and interviewed the staff on duty. Further interview revealed it had been determined Resident #4 pulled the fire alarm which deactivated the locked doors allowing the resident to access the outside. The CED further revealed Resident #4 wandered the facility prior to the elopement; however, had made no attempts to exit the facility as he/she had been easily redirected. In addition, he stated the facility had no knowledge Resident #4 had ever attempted to elope. The facility alleged the following was implemented to remove the Immediate Jeopardy and correct the deficiency on 09/09/2021: 1. Resident #4 was returned to the facility on [DATE] and was assessed for injuries. No injuries were identified, and the Physician and responsible party were notified. 2. A body audit was completed on 09/06/2021 by a licensed nurse with no injuries noted. The Physician and responsible party were notified by a licensed nurse on 09/06/2021 with new orders received. 3. An assessment was completed of Resident #4 by a licensed nurse which included vital signs which had been in the usual range for the resident. Resident #4 was noted by a licensed nurse to move all extremities without difficulty and without complaints of pain or discomfort. 4. Resident #4's elopement assessment was reviewed and updated on 09/07/2021 by the Center Nurse Executive. The Wander Guard on the resident had been checked to ensure it was working properly by the licensed nurse on 09/07/2021. 5. Social Services, the CNE or CED interviewed Resident #4 and the resident stated he/she just wanted to go home to see his/her dog. Resident #4 had a BIMS score of five (5). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. Resident #4's care plan/Kardex was updated on 09/06/2021 by the CNE to include review of elopement evaluation and Wander Guard. 7. RN and LPN Charge Nurses immediately completed a visual validation of the facility's resident census check. All residents, 69 of 69 were present inside the facility. This was completed on 09/06/2021 at 7:20 PM. 8. Maintenance director checked all doors to ensure they were functioning correctly. 9. Staff interviews regarding the elopement were conducted by the CNE and or CED with staff who had been working at the time of the event on 09/06/2021. 10. Record review of elopement assessments, care plans, and Kardex's was conducted on all residents residing in the facility. 69 of 69 facility residents records were reviewed starting 09/07/2021 and completed on 09/07/2021 by the CNE, Unit Managers, RN and/or LPN to identify any new elopement risks and determine whether the care plan and Kardex reflected the current needs of the resident. The elopement risk evaluations for all at risk residents, care plans and Kardex's were reviewed and updated by the licensed nurse. 11. Staff re-education was immediately initiated by the CED, CNE, NPE, Unit Managers and Licensed Nurses beginning on 09/07/2021. All remaining staff members and newly hired staff members completed education prior to reporting for their next assigned shifts. The re-education for all staff included: (A.) Review of Center Policies on elopement prevention and management to include exiting the facility to determine that a resident was not outside the facility, and including securing the fire doors when the alarm was sounding. (B.) Supervision needs of residents assessed as at risk for elopement. (C.) Review of the facility policy for following each resident's person-centered care plan or Kardex regarding residents at risk for elopement. (D.) All employees including contract employees were to complete a posttest to validate their learning. A passing score of 100% was required. Staff and contract employees not available were to be provided the re-education by the CNE, Resource Nurse, Unit Managers and/or Licensed Nurses, and complete a posttest upon the day of their return to work before providing care. (E.) All newly hired employees and contract employees were to have the elopement education by the CNE, HR/Payroll, Resource Nurse, Unit Managers and or Licensed Nurses and complete a posttest during orientation. 12. Elopement drills were completed over three (3) different shifts from 09/07/2021 through 09/08/2021, with no concerns identified. Elopement Drills were to be conducted daily for two (2) weeks including weekends, then three (3) times per week for two (2) weeks then weekly for eight (8) weeks, then every other week for eight (8) weeks then monthly for one (1) month then as determined by the facility's QAPI Committee. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	13. Fire Drills were completed over three (3) shifts on 09/07/2021 with no concerns identified. Fire drills were to be conducted daily for two (2) weeks including weekends, then three (3) times per week for two (2) weeks, then weekly for eight (8) weeks, then every other week for eight (8) weeks then monthly for one (1) month then as determined by the QAPI Committee. 14. Interviews of five (5) random staff members daily regarding interventions on care plan for residents who were at risk of elopement were to be completed by the CNE, CED, Charge Nurses and Unit Managers, daily for two (2) weeks including weekends, then three (3) times per week for two (2) weeks, then weekly for eight (8) weeks, then every other week for eight (8) weeks then monthly for one (1) month then as determined by the QAPI Committee. 15. Visual Observation Audits were to be conducted by the CNE, CED Department Managers to determine if staff were following the residents' plan of care to ensure residents who were at risk for elopement were not allowed to exit the facility without supervision. The Visual Observation Audits were to be conducted daily for two (2) weeks including weekends, then three (3) times per week for two (2) weeks, then weekly for eight (8) weeks, then every other week for eight (8) weeks then monthly for one (1) month then as determined by the QAPI Committee. 16. An Ad Hoc QAPI Committee meeting was held on 09/07/2021 with the Medical Director, for recommendations in developing the action plan including audits, re-education, and compliance monitors for residents at risk for elopement. Results of the elopement drills were to be reviewed daily by the Administrator and CNE for follow up with staff. 17. Elopement drills were to be reviewed at the QAPI Committee meetings monthly for six (6) months for any additional follow up and or in servicing until the issues were resolved and ongoing thereafter as determined by the QAPI Committee. The QAPI Committee members might include Administrator, DON, ADON, Admissions and Marketing Coordinator, Social Services Director, Reimbursement Manager, Maintenance Director, Nurse Practice Educator, and Nutrition Services Director. The State Agency verified the facility's action plan had been implemented and the deficiency was corrected on 09/09/2021: 1. Review of the facility's investigation, timeline of events and Resident #4's every fifteen (15) minute check log initiated 09/06/2021 at 6:45 PM, confirmed staff assisted the resident back into the facility. Review of a Change in Condition (CIC) Evaluation dated 09/06/2021 revealed Resident #4 was assessed by the Center Nurse Executive (CNE) on 09/06/2021. Continued review of the CIC revealed the responsible party had been made aware of the incident on 09/06/2021 at 6:49 PM, and the APRN was made aware at 6:55 PM on that date. 2. Review of a Skin Check and a CIC Evaluation dated 09/06/2021 at 7:54 PM revealed LPN #5 and the CNE completed a full body audit of Resident #4. The resident's responsible party was made aware on 09/06/2021 at 6:49 PM and the APRN was made aware at 6:55 PM. 3. Review of the CIC dated 09/06/2021 at 7:54 PM revealed LPN #5 and the CNE completed a head-to-toe assessment of Resident #4, and the resident was found to have no injuries, and voiced no pain or concerns. The resident's vital signs were obtained and were within normal limits for him/her. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185401	A. Building B. Wing	05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edmonson Nursing and Rehabilitation Center	813 South Main Street Brownsville, KY 42210

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. Review of Resident #4's Elopement Risk Evaluation dated 09/07/2021 and completed by the CNE, revealed the resident had been assessed as at risk for elopement. Review of the Progress Note dated 09/06/2021 at 7:00 PM and signed by the CNE, revealed Resident #4's Wander Guard bracelet had been checked and determined to be functioning properly when the resident was returned to the facility. 5. Review of the General Progress Note dated 09/07/2021 at 2:40 PM, revealed an interview with Resident #4 had been completed by Social Services. Interview with the Social Services staff person on 05/03/2022 at 2:40 PM, revealed she interviewed Resident #4 about exiting the facility and the resident told her he/she had recently lost his/her spouse and son, and the resident was feeling down. She revealed Resident #4 wanted to see his/her dog and was going to walk home. 6. Review of Resident #4's elopement care plan dated 05/24/2021 and the CNA Kardex dated 09/13/2021, revealed the care plan and the CNA Kardex were revised on 09/06/2021 by the CNE to include the following interventions: 1:1 monitoring as needed; visual checks of the resident every fifteen (15) minutes; compassionate care visits as needed; and activities to provide an animated puppy to comfort resident. 7. Review of the facility's Midnight Census Report dated 09/06/2021 at 7:00 PM, confirmed a head count of all facility residents had been conducted by licensed staff and the CNE. Review revealed the head count determined all 69 of 69 facility residents were present. 8. Review of the facility's Daily Check Sheet confirmed door checks had been completed by the Maintenance Director on 09/06/2021 through 09/10/2021. Interview with the Maintenance Director on 04/20/2022 at 2:07 PM, revealed he completed daily door checks beginning on 09/06/2021 through 09/10/2021 with no issues identified. 9. Review of the facility investigation revealed witness statements were obtained from staff who had been working when Resident #4 exited the facility on 09/06/2021. 10. Review of the Assessment History for Elopement revealed the Elopement Assessments were completed for 69 of 69 facility residents on 09/07/2021 by the CNE with no new elopement risks identified. 11. Review of the facility's education rosters revealed education had been provided for the facility staff by the CNE regarding the following facility policies and procedures: Elopement Prevention and Management; Supervision needs for residents at risk for elopement; and Person-Centered Care Plan. Review of the facility education post-tests, dated 09/07/2021 through 09/09/2021, revealed education had been provided for facility staff with a posttest completed and this was ongoing with new hires and or contracted staff. Interview on 05/03/2022: at 1:20 PM with LPN #3; LPN #9 at 1:25 PM; with CNA #3 at 1:30 PM; CNA #11 at 4:05 PM; and CNA #12 at 4:18 PM revealed they had all received education provided by the NPE and CNE on what to do if there was a missing resident, on updating residents' care plans/Kardexes, on elopement drills, and fire drills. The staff interviewed revealed all had completed a posttest after receiving the education. (continued on next page)

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	185401	A. Building B. Wing	05/04/2022

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the NPE on 05/03/2022 at 2:49 PM revealed she provided education on the facility's policy and procedure regarding resident elopement and the educated staff had taken a posttest. Per interview, she had also provided the education and posttests for new employees as well as agency/contracted staff during their orientation process. Interview with RN #2 at 3:05 PM, revealed he had a hire date of 04/25/2022 and was currently in orientation. He revealed he had received education from the CNE, NPE and the maintenance person who all had gone over the facility's elopement process and drills, and fire drills. Interview with CNA #13 on 04/25/2022 at 10:24 AM, revealed she was hired on 04/22/2022, and was a contract agency employee. Per interview, 04/25/2022 was her third day of working at the facility. She stated she had received education from the NPE during her orientation process on the facility's elopement process, on following the residents' Kardex and on supervising residents who wandered. 12. Review of the facility's Logbook Documentation revealed Elopement Drills had been conducted 09/07/2021 through 03/10/2022 across all shifts including weekends as outlined in the facility's allegation of compliance. Further review revealed the Elopement Drills had been completed as of 03/10/2022. 13. Review of the facility's Logbook Documentation revealed Fire Drills were conducted 09/07/2021 through 03/10/2022 across all shifts including weekends as outlined in the facility's allegation of compliance. Further review revealed the Fire Drills had been completed as of 03/10/2022. Interview with the Maintenance Director on 04/20/2022 at 2:07 PM, confirmed the elopement and fire drills were conducted over three (3) shifts o [TRUNCATED]