STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045438	A. Building B. Wing	11/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Village Medical Center	6400 Trinity Drive Pine Bluff, AR 71603

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38401 Based on record review and interview, the facility failed to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown origin and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator and other officials in accordance with State law through established procedures for 3 (Residents #1, #4 and #5) of 3 sampled residents whose Incident and Accident Reports were reviewed. This failed practice had the potential to affect all 76 residents who resided in the facility as identified on the Daily Census provided by the Administrative Assistant on 11/02/22. The findings are: 1. The facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, provided by the Administrator on 11/04/2022 at 9:56 a.m. documented, .Reporting Allegations to the Administrator and Authorities 1. If resident abuse, neglect . is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law . 3. Immediately is defined as: a. within two hours of an allegation involving abuse . or within 24 hours of an allegation that does not involve abuse . 2. Resident #1 was admitted to the facility on [DATE] and had a diagnosis of Alzheimer's Disease with Late Onset. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/21/22 documented the resident scored 12 (8-12 indicates moderately cognitively impaired) on a Brief Interview for Mental Status (BIMS) and exhibited no wandering behaviors, requires limited physical assistance of one person with walking in the room, locomotion on and off the unit, supervision of one person with walking in the corridor, and used a wheelchair. a. The Care Plan with an initiated date of 10/20/22 documented, .attempts unsuccessful attempts to exits from the facility . Follow familiar routines. Wander guard. Check placement of wander guard to right ankle each shift . b. The OLTC (Office of Long Term Care) Incident and Accident Report (I&A) Form 7734 dated 10/28/22 documented .Date & Time of Discovery: 10/28/2022 1200 [12:00 p.m.] . Type of Incident: Neglect . c. The Fax Cover Sheet documented the the OLTC Office received the I&A report on 10/31/22 at 2:00:04 PM. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #4 had a diagnosis of Unspecified Dementia with Behavioral Disturbances. The Quarterly MDS with an ARD of 08/25/22 documented the resident was moderately impaired in cognitive skills for daily decision-making per a Staff Assessment for Mental Status (SAMS) and required extensive physical assistance of two plus persons with bed mobility and transfers, was not steady, only able to stabilize with staff assistance with moving from seated to standing position and surface to surface transfer and had had no falls. a. The Care Plan with a revision date of 8/31/22 documented, .impaired cognitive function and impaired thought processes . has diagnosis of Seizures at risk for complications, and has pressure ulcers due to immobility . b. OLTC Incident and Accident Report (I&A) dated 05/21/22 documented, Date of I&A 05/21/2022 . Type of Incident: Abuse: Physical . Date/Time Administrator Notified: 05/23/2022 @ [at] 0810 [8:10 a.m.] . Date/Time of Alleged Incident: 05/21/2022 @ 0154 [1:54 a.m.] . 4. Resident #5 had a diagnosis of Unspecified Symptoms and Signs Involving Cognitive Function and Awareness. The Discharge Return Anticipated MDS with an ARD of 06/23/22 documented the resident scored 6 (0-7 indicates severely cognitively impaired) on a BIMS and required extensive physical assistance of one person with bed mobility and dressing and was totally dependent on two plus persons with transfers, was not steady, was only able to stabilize with staff assistance with moving from seated to standing position and surface to surface transfer and had not had any falls since admission/reentry. a. The Care Plan with an initiated date of 06/21/22 documented, .The resident has limited physical mobility . is non ambulatory at this time . The resident uses a w/c [wheelchair] for locomotion . b. OLTC Incident and Accident Report (I&A) dated 06/23/22 documented, .Date and Time of Discovery: 1600 [4:00 p.m.] . Type of Incident: Neglect . c. The Fax Cover Sheet documented the OLTC Office received the I&A report on 06/23/22 at 11:47:07 p.m. 39316 5. On 11/3/2022 at 12:55 p.m., the Surveyor asked Certified Nursing Assistant (CNA) #1, Who do you report any allegations of abuse, neglect, or elopement to? CNA #1 replied, To the Charge Nurse. The Surveyor asked, If a resident elopes, what are you supposed to do? CNA #1 replied, Notify the Charge Nurse and they follow chain of command. The Surveyor asked, Why is reporting any allegation of abuse, neglect, or elopement important? CNA #1 replied, Because lives are at stake. The Surveyor asked, What interventions are in place for residents that wander or are an elopement risk? CNA #1 replied, We re-direct and we have wanderguards. The Surveyor asked, When should allegations of abuse, neglect, and or elopement be reported? CNA #1 replied, Every time it happens, immediately. The Surveyor asked, Who is responsible for reporting abuse, neglect, or elopement to the state office or agency? CNA #1 replied, Anyone could. The Surveyor asked, What is the timeframe an allegation of abuse, neglect, or an elopement is to be reported to the state agency? CNA #1 replied, I really don't know, right after everything that happens. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. On 11/3/2022 at 1:01 p.m., the Surveyor asked Licensed Practical Nurse (LPN) #1, Who do you report any allegations of abuse, neglect, or elopement to? LPN #1 replied, The Charge Nurse, the DON [Director of Nursing], and the Administrator. The Surveyor asked, If a resident elopes, what are you supposed to do? LPN #1 replied, Call a Code Silver, notify everyone on our unit, and hopefully they don't get too far, and come up with an intervention. The Surveyor asked, Why is reporting any allegation of abuse, neglect, or elopement important? LPN #1 replied, It's not acceptable. The Surveyor asked, What interventions are in place for residents that wander or are an elopement risk? LPN #1 replied, One had a wanderguard on, but it didn't go off for whatever reasons, we don't really have one on. One, because they aren't care planned. The Surveyor asked, When should allegations of abuse, neglect, and or elopement be reported? LPN #1 replied, Immediately. The Surveyor asked, Who is responsible for reporting abuse, neglect, or an elopement to the state office or agency? LPN #1 replied, Anybody that has that information, but normally it's the DON or the Administrator. The Surveyor asked, What is the timeframe an allegation of abuse, neglect, or an elopement is to be reported to the state agency? LPN #1 replied, 24 to 48 hours. 7. On 11/3/2022 at 2:09 p.m., the Surveyor asked the Social Director (SD), Who do you report any allegations of abuse, neglect, or elopement to? The SD replied, To the Administrator. The Surveyor asked, If a resident elopes, what are you supposed to do? The SD replied, Bring the resident back to the facility and report to the DON and the Administrator. The Surveyor asked, Why is reporting any allegation of abuse, neglect, or elopement important? The SD replied, Because we need to let someone know that person got out or was in another area. The Surveyor asked, What interventions are in place for residents that wander or are an elopement risk? The SD replied, Wanderguard system and alarms on the doors. The Surveyor asked, When should allegations of abuse, neglect, and or elopement be reported? The SD replied, As soon as possible. The Surveyor asked, Who is responsible for reporting abuse, neglect, or an elopement to the state office or agency? The SD replied, The DON and the Administrator. The Surveyor asked, What is the timeframe an allegation of abuse, neglect, or an elopement is to be reported to the state agency? The SD replied, As soon as possible, less than 30 to 45 minutes. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. On 11/4/2022 at 8:26 a.m., the Surveyor asked the DON, Who do you report any allegations of abuse, neglect, or elopement to? The DON replied, The Administrator. The Surveyor asked, If a resident elopes, what are you supposed to do? The DON replied, Call a Code Silver, everyone goes looking, we have a protocol. The Surveyor asked, Why is reporting any allegation of abuse, neglect, or elopement important? The DON replied, The residents are top priority and we've got to keep them safe. The Surveyor asked, What interventions are in place for residents that wander or are an elopement risk? The DON replied, They have wanderguards, increase activities, like re-direction. The Surveyor asked, When should allegations of abuse, neglect, and or elopement be reported? The DON replied, Immediately. The Surveyor asked, Who is responsible for reporting abuse, neglect, or an elopement to the state office or agency? The DON replied, Myself and the Administrator. The Surveyor asked, What is the timeframe an allegation of abuse, neglect, or an elopement is to be reported to the state agency? The DON replied, Two hours. The Surveyor asked, Why was the physical abuse on [Resident #4] that happened on 5/21/2022, not reported to the Office of Long Term Care [OLTC] until 5/23/2022? The DON replied, I wasn't the DON at that time, so I'm taking the fall for that one, and no, it was not within the time frame. The Surveyor asked, Why was the reportable for [Resident #1] dated 10/28/2022 [elopement], not reported to OLTC until 10/31/2022? The DON replied, I did not file the report, and no that is not an acceptable time frame for reporting to OLTC. The Surveyor asked, When should abuse/elopement be reported to OLTC? The DON replied, I've always been told two hours. The Surveyor asked, What are your expectations from your staff regarding following the facilities policy and procedures and the Centers for Medicare and Medicaid [CMS] Guidelines? The DON replied, I expect them to follow them 100 percent. 9. On 11/4/2022 at 10:07 a.m., the Surveyor asked the Administrator, Who do you report any allegations of abuse, neglect, or elopement to? The Administrator replied, Inside the facility, I report to the Executive Director, I or my designee report to the Physician, Medical Director, the DON, and family within two hours. The Surveyor asked, If a resident elopes, what are you supposed to do? The Administrator replied, Call a Code Silver, search the perimeter, run a census and account for residents. All departments are involved. Do a man hunt. The Surveyor asked, What interventions are in place for residents that wander or are an elopement risk? The Administrator replied, Every two hour rounds, wanderguards, keypad on the door, we do in-services on rounding. The Surveyor asked, When should allegations of abuse, neglect, and or elopement be reported? The Administrator replied, Immediately. The Surveyor asked, Who is responsible for reporting abuse, neglect, or an elopement to the state office or agency? The Administrator replied, The Administrator or designee. The Surveyor asked, What is the timeframe an allegation of abuse, neglect, or an elopement is to be reported to the state agency? The Administrator replied, By eleven o'clock the next day for the 7734 and the 762 [Facility Investigation Report for Resident Abuse, Neglect, Misappropriation of Property, & Exploitation of Residents in Long Term Care Facilities] is 5 days mailed in. The Surveyor asked, Why was the physical abuse on [Resident #4] that happened on 5/21/2022, not reported to the OLTC until 5/23/2022? The Administrator replied, The Administrator was notified on 5/23/2022 of the fall on 5/21/2022, they should have notified me of the fall as soon as they found out. The Surveyor asked, Why was [Resident #1's] elopement not reported to OLTC until three days later? The Administrator replied, When I started the 7734 on Friday 10/28/2022 afternoon, I was thinking the next business day reporting and when I came in Monday 10/31/2022, I read over my abuse information flyer and realized I should have reported it on Friday 10/28/2022 afternoon. It would have been in the timeframe. The Surveyor asked, What are your expectations from your staff regarding following the facilities policy and procedures and the CMS guidelines? The Administrator replied, I expect them to follow them to the letter. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. The facility policy titled, [Facility] Elopement Policy and Procedure . Revision 3, provided by the Director of Nursing (DON) on 11/04/22 at 9:17 a.m. documented, .Purpose: The primary goal of the Elopement Policy and Procedure is to provide a course of action for all personnel to follow in the event of an elopement. Ensure all residents/patients are accounted for and ensure guidelines in identifying and providing safety to all patients/resident at risk of wandering . Elopement: The definition of Elopement used by the American Health Care (AHRQ) is when a resident's location is unknown.Duties of Personnel: The person in Charge: When discovered a Resident is missing, the Alert for a Missing Adult will be paged CODE SILVER by the Charge Nurse if, after a reasonable search by staff for a resident/patient, shows the individual to be unaccounted for . Upon return of the resident/patient to the facility: .Document the elopement incident in the medical record and complete an incident report .

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 38401 Based on observation, record review, and interview, the facility failed to ensure G-Hall, which was under construction and was unsecured with multiple hazards, was not accessible to the residents, which resulted in an elopement of Resident #1 due to the fire door being propped opened with a chunk of concrete. This failed practice had the potential to affect 32 residents who were ambulatory by any means as documented on a list provided by the Administrator on 11/04/22 at 9:57 a.m. This failed practice resulted in an Immediate Jeopardy, which caused or could have caused serious harm, injury, or death to Resident #1 who had eloped from the facility on 10/28/22. The Administrator was notified of the current Immediate Jeopardy on 11/02/22 at 4:58 p.m. The findings are: 1. Resident #1 was admitted to the facility on [DATE] and had a diagnosis of Alzheimer's Disease with Late Onset. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/21/22 documented the resident scored 12 (8-12 indicates moderately cognitively impaired) on a Brief Interview for Mental Status (BIMS) and exhibited no wandering behaviors, requires limited physical assistance of one person with walking in the room, locomotion on and off the unit, supervision of one person with walking in the corridor, and used a wheelchair. a. The Physician's Order dated 10/21/22 documented, .May place wander guard to Right ankle, and Check wander guard battery and placement every shift . b. The Care Plan documented, .attempts unsuccessful attempts to exits from the facility. 10/28/2022: .exit G-Hall door that was let open by maintenance . Follow familiar routines. Wander guard. Check placement of wander guard to right ankle each shift. Date Initiated: 10/20/2022 . Staff inserviced to make sure doors are closed at all times. Date Initiated: 10/20/2022 . c. The Nurse's Note dated 10/28/22 at 12:30 p.m. documented, .Resident has been very agitated this shift. continuously exit seeking and ambulating without assistance. Received in report that resident had been up all night packing clothes and personal belongings in attempt to leave the facility. This nurse has kept close watch on resident majority of shift as much as possible. This nurse at nurse station charting and receive a call from administrator asking where resident was. This nurse stated that she believed resident was up front in dining room because he was just in front of nurses station. administrator stated she thought he was missing and that this nurse needed to go look for him. This nurse along with other staff members searched for resident in facility unable to find resident. This nurse arrived at station 2 and noted DON and Administrator at the nurses station discussing that resident was brought to administrators office. This nurse asked several times who brought resident in. Social Director this nurse that she was standing outside smoking and her and another staff member brought resident in. They found resident in the parking lot . d. The Nurse's Note dated 10/28/22 at 1:19 p.m. documented, .Elopement Evaluation: History of elopement while at home: No. Wandering behavior a pattern or goal-directed: Yes. Wanders aimlessly or non-goal-directed: No. Wandering behavior likely to affect the safety or well-being of self / others: Yes. Wandering behavior likely to affect the privacy of others: No. Recently admitted or readmitted (within past 30 days) and has not accepted the situation: Yes. Elopement Score: 6.0 . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	e. The Nurse's Note dated 10/28/22 at 1:21 p.m. documented, wander guard was in place at the time of elopement and alarms did not go off . f. The Nurse's Note dated 10/28/22 at 2:14 p.m. documented, .APRN [Advance Practice Registered Nurse] was notified in dining room this am during halloween party of resident's behavior. APRN stated that she would order resident something to help him sleep and PRN [as needed] ativan. Resident eloped and APRN was notified of elopement and order one time dose of Ativan . g. On 11/02/22 at 2:28 p.m., Resident #1 was in his room in his wheelchair (w/c). When this Surveyor attempted to talk to him his words were garbled and did not make sense. h. On 11/02/22 at 3:14 p.m., during initial rounds on the G-Hall, which was under construction, the fire doors were closed. Surveyors pushed the bar on the doors and the doors opened and the Surveyors were able to access the hallway. The hall and rooms had wiring hanging down from the ceiling, a ladder, a metal plate, copious amounts of insulation and steel hex webbing were all up and down the halls and in the resident rooms. i. On 11/02/22 at 4:36 p.m., the Surveyor asked the Administrator, How did [Resident #1] get out of the facility? The Administrator replied, The maintenance man had the fire doors opened, and the video show's him going down the hall, in his w/c. He got to the exit, stood up and walked outside. The exit door was propped opened with a junk of concrete. j. On 11/02/22 at 4:44 p.m., the Surveyor asked Certified Nursing Assistant (CNA) #2, Can you tell me why the hall under construction is accessible to residents? CNA #2 replied, It shouldn't be. The Surveyor asked, Why not? CNA #2 replied, Because of the hazards down there. k. On 11/02/22 at 4:47 p.m., the Surveyor asked Licensed Practical Nurse (LPN) #2, Can you tell me why the hall under construction is accessible to residents? LPN #2 replied, Because it's a fire door and we can't lock fire doors. l. On 11/02/22 at 5:18 p.m., the Surveyor asked Maintenance #4 Why won't the exit doors at the ends of every hall not open after pushing on the bar for greater than 2 minutes? Maintenance #4 replied, You have to have the access code in order for the door to open. If the fire alarm is triggered the doors release. The Surveyor asked, Why won't the exit doors at the ends of the halls not open when pushed on? He stated, You have to enter the code. The Surveyor asked Maintenance #4, How does someone exit the building if there is an emergency? Maintenance #4 replied, The fire alarm disables the system, and the doors will be unlocked. m. On 11/02/22 at 7:07 p.m., the Surveyor asked Maintenance #2 Why were the fire doors on G-Hall left accessible to residents? Maintenance #2 replied, We didn't block it off, we didn't know we could lock it. n. On 11/02/22 at 7:08 p.m., the Surveyor asked Maintenance #1 Why were the fire doors on G-Hall left accessible to residents? Maintenance #1 replied, We had signs, we didn't know we could lock it. o. On 11/02/22 at 7:09 p.m., the Surveyor asked Maintenance #3 Why were the fire doors on G-Hall left accessible to residents? Maintenance #3 replied, We thought closed doors and signs would be enough. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	p. On 11/02/22 at 7:12 p.m., the Surveyor asked Maintenance #2, Why won't the exit doors at the ends of the halls not open when pushed on? He stated, You have to enter the code. The Surveyor asked, How does someone exit the building if there is an emergency? Maintenance #2 replied, The fire alarm disables the system, and the doors will be unlocked. q. On 11/02/22 at 7:15 p.m., the Surveyor asked Maintenance #1 When will the exit doors at the ends of the halls open? Maintenance #1 replied When the bar is pushed. The Surveyor asked Maintenance #1 to push on the bar, it failed to open after he applied some very aggressive pushing. Maintenance #1 replied, I thought they'd open after 45 seconds of pushing. r. On 11/03/22 at 11:23 a.m., the Surveyor asked the Fire Marshall about the exit doors not opening after being pushed for up to 3 minutes. The Fire Marshall replied, These doors have remained like this since the building was built greater than [AGE] years ago. It's made to release when the fire alarm is set. The Surveyor asked, What if there were an active shooter in the building and I'm a visitor or a staff member so scared that I can't put the code in? The Fire Marshall replied, Oh my I've never thought about that, that is a very valid question. s. On 11/03/22 at 11:35 a.m., the Surveyor asked Maintenance #1, Describe in your words what happened the day [Resident #1] eloped? Maintenance #1 replied, Me and a co-worker were tearing out debris from the remodel of the ceiling in the hall, so we propped the [exit] door open with a chunk of concrete after disabling the alarm system to the door. Our supervisor had another project to go on and needed our help at the lodge in the next building. We had to leave, and I inadvertently left the exit door propped open. The Surveyor asked, How long were you gone? Maintenance #1 replied, For about one to one and half hours. When we came back around the G-Hall, the exit door was shut, and the Administrator informed me and my supervisor of what had happened. t. On 11/03/22 at 12:42 p.m., the Surveyor asked CNA #1, What is a wanderguard? CNA #1 replied, It's a bracelet that alerts you they got too close to the door. The Surveyor asked, Why do some residents have a wanderguard? CNA #1 replied, If they have dementia or are a wanderer. The Surveyor asked, How do you know the wanderguard is working properly? CNA #1 replied, When they get close to a door it goes off and the nurse reports it. The Surveyor asked, Where is the monitoring documentation at? CNA #1 replied, Somewhere in our software system. u. On 11/3/2022 at 12:55 p.m., the Surveyor asked Certified Nursing Assistant (CNA) #1, If a resident elopes, what are you supposed to do? CNA #1 replied, Notify the Charge Nurse and they follow chain of command. The Surveyor asked, What interventions are in place for residents that wander or are an elopement risk? CNA #1 replied, We re-direct and we have wanderguards. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	v. On 11/03/22 at 1:01 p.m., the Surveyor asked LPN #1, What is a wanderguard? LPN #1 replied, The placement is to notify you they're out of place. The Surveyor asked, Why do some residents have a wanderguard? LPN #1 replied, Due to their state of mind or diagnosis. The Surveyor asked, How do you know the wanderguard is working properly? LPN #1 replied, I have a machine to check the wanderguard and the door sensor. The Surveyor asked, Who is responsible for ensuring placement and functioning? LPN #1 replied, I am, I have a check off in the software every shift. The Surveyor asked, Where is the monitoring documentation at? LPN #1 replied If something is wrong, the system will report it to the DON, who will help me figure out why it's not working. The Surveyor asked, If a resident elopes, what are you supposed to do? LPN #1 replied, Call a Code Silver, notify everyone on our unit, and hopefully they don't get too far, and come up with an intervention. The Surveyor asked, What interventions are in place for residents that wander or are an elopement risk? LPN #1 replied, One had a wanderguard on, but it didn't go off for whatever reasons, we don't really have one on. One, because they aren't care planned. The Surveyor asked, Tell me about the situation that happened with [Resident #1] on 10/28/2022 with the elopement? LPN #1 replied, [Resident #1] was more confused, exit seeking. He had a wanderguard on. I re-directed him at the Halloween party. Every time I walked away from him; I was being paged back to him. Me and a couple other nurses tried to re-direct him, but he was adamant he was going outside to get to his wife. He was there, then he was gone. I received a phone call from the Administrator asking where was [Resident #1]. The Surveyor asked, Why did the Administrator call you? LPN #1 replied, She was in her office, and we left him for five minutes, she asked where is [Resident #1], I said he's right there. The CNA said he was right there. The Administrator said I think he's missing, so I hung up the phone and went looking for him, and he was in her office. The Surveyor asked, How did [Resident #1] end up in the Administrator's Office? LPN #1 replied, I assume he just went out the door, but no one reported to me he was outside, but I was headed to the front and the Social Director/Worker said we were outside smoking, and [Resident #1] came walking through the parking lot. [Resident #1] was sitting in the Administrator's Office, everyone was trying to figure out how he got out. I asked, what was the intervention and the DON said I don't know, I'm going to get with the Administrator. The Surveyor asked, Was the door left open [propped open]? LPN #1 replied, Yes, the outside door was open [G-Hall], but the first set of doors were closed, but accessible and yes there was construction going on the G-Hall. 39316 w. On 11/3/2022 at 2:09 p.m., the Surveyor asked the Social Director (SD), If a resident elopes, what are you supposed to do? The SD replied, Bring the resident back to the facility and report to the DON and the Administrator. The Surveyor asked, What interventions are in place for residents that wander or are an elopement risk? The SD replied, Wanderguard system and alarms on the doors. The Surveyor asked, Tell me about the situation that happened with [Resident #1] on 10/28/2022 with the elopement, were you here that day? The SD replied, Yes, I was working, I was outside. When I got ready to come back in, I saw [Resident #1] coming around the building pushing his wheelchair. The Surveyor asked, Did [Resident #1] have a wanderguard on? The SD replied, Not sure. The Surveyor asked, Was the door alarming? The SD replied, No, I ran to him, sat him in his wheelchair, and took him to the Administrator's Office and told her I found him outside coming around the building. The Surveyor asked, Do you know how long he was outside before you found him? The SD replied, I have no idea. The Administrator called back to the Nurses Station 3, where he resides, she tells the nurse that we had brought him in from outside. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045438	A. Building B. Wing	11/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Village Medical Center	6400 Trinity Drive Pine Bluff, AR 71603

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	x. On 11/4/2022 at 8:26 a.m., the Surveyor asked the DON, If a resident elopes, what are you supposed to do? The DON replied, Call a Code Silver, everyone goes looking, we have a protocol. The Surveyor asked, What interventions are in place for residents that wander or are an elopement risk? The DON replied, They have wanderguards, increase activities, like re-direction. The Surveyor asked, Tell me about the situation that happened with [Resident #1] on 10/28/2022 with the elopement, were you here that day? The DON replied, I was here that day, and I'm the one who found the door at the end of G-Hall propped opened with a piece of concrete and automatically shut it. I did not see any residents. I knew he had gotten out. The Surveyor asked, How did you know [Resident #1] got out? The DON replied, The SD was outside and saw him and brought him in. The Surveyor asked, Who left the door propped open? The DON replied, The Maintenance Men. We got him [Resident #1] in, we tried to keep him up front and started the in-service. The Surveyor asked, It documents the facility did one on one, do you have that documentation? The DON replied, I know the wife came and set with him for a while after I called her. I have where she was here, but not when she left. We don't have any documentation that we did one on one because we don't have the staff. The Surveyor asked, Did [Resident #1] have a wanderguard on? The DON replied, Yes, but with the door propped opened, it wouldn't alarm. The Surveyor asked, What are your expectations from your staff regarding following the facilities policy and procedures and the Centers for Medicare and Medicaid [CMS] Guidelines? The DON replied, I expect them to follow them 100 percent. y. On 11/4/2022 at 10:07 a.m., the Surveyor asked the Administrator, If a resident elopes, what are you supposed to do? The Administrator replied, Call a Code Silver, search the perimeter, run a census and account for residents. All departments are involved. Do a man hunt. The Surveyor asked, What interventions are in place for residents that wander or are an elopement risk? The Administrator replied, Every two hour rounds, wanderguards, keypad on the door, we do in-services on rounding. The Surveyor asked, Were you here the day [Resident #1] eloped. The Administrator replied, Yes. The Surveyor asked, Tell me about that? The Administrator replied, I do know it was at the noon hour and the MDS Coordinator and the SD/Worker came into my office pushing [Resident #1] in his wheelchair. The SD said, 'we were out in the parking lot and saw [Resident #1] coming around the corner of the building' and they brought him into my office. I asked [Resident #1] what he was doing, and he said he was, 'Looking for his Volvo or Ford Explorer, he needed to get to [City]'. I asked the SD and MDS Coordinator to go do the Silver Code, the DON said she had started on the end he went out. The Surveyor asked, How did [Resident #1] get out of the building? The Administrator replied, I found out from the DON that the G-Hall door was held open with a chunk of concrete. The Surveyor asked, Who propped the G-Hall exit door open? The Administrator replied, I don't know. I did not witness anyone prop the door open. The Surveyor asked, Did [Resident #1] walk through the G-Hall that was under construction to the exit door? The Administrator replied, He ambulated himself through the G-Hall in his wheelchair, and at the exit door, exited the building pushing his wheelchair and was intercepted by staff at the generator. The Surveyor asked, What are your expectations from your staff regarding following the facilities policy and procedures and the CMS guidelines. The Administrator replied, I expect them to follow them to the letter. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	z. The facility policy titled, [Facility] Elopement Policy and Procedure . Revision 3, provided by the Director of Nursing (DON) on 11/04/22 at 9:17 a.m. documented, .Purpose: The primary goal of the Elopement Policy and Procedure is to provide a course of action for all personnel to follow in the event of an elopement. Ensure all residents/patients are accounted for and ensure guidelines in identifying and providing safety to all patients/resident at risk of wandering . Elopement: The definition of Elopement used by the American Health Care (AHRQ) is when a resident's location is unknown.Duties of Personnel: The person in Charge: When discovered a Resident is missing, the Alert for a Missing Adult will be paged CODE SILVER by the Charge Nurse if, after a reasonable search by staff for a resident/patient, shows the individual to be unaccounted for . Upon return of the resident/patient to the facility: .Document the elopement incident in the medical record and complete an incident report . aa. The facility policy titled, Accidents and Incidents - Investigating and Reporting, provided by the Administrator on 11/04/2022 at 9:56 a.m. documented, .The nurse supervisor/charge nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident . 3. This facility is in compliance with current rules and regulations governing accidents and/or incidents involving a medical device . bb. The facility policy titled, Hazardous Areas, Devices and Equipment, provided by the Administrator on 11/04/2022 at 9:56 a.m. documented, .All hazardous areas, devices and equipment in the facility will be identified and address appropriately to ensure resident safety and mitigate accident hazards to the extent possible . Identification of Hazards 1. A hazard is defined as anything in the environment that has the potential to cause injury or illness. Examples of environmental hazards include but are not limited to the following: a. Equipment and devices that are left unattended .; .c. Sharp objects that are accessible to vulnerable residents; .f. Objects in the hallways that obstruct a clear path; .j. Furniture that is unstable or position at an improper height for residents; or k. Disabled locks, latches or alarms . 2. The Immediate Jeopardy was removed on 11/02/22 at 7:59 p.m., when the following Plan of Removal was implemented by the facility: a. All residents have been checked/facility wide audit to ensure that no residents were located on the G Hall. There were no residents identified as being on the G Hall. A staff member was placed outside of the G Hall entrance (fire doors) to monitor for any entrances or exits. She/he will be documenting every 15 minutes, every shift. Completion date 11/02/22. b. All items that were located on the floor of the G Hall hallway were removed and placed out of pathway of anyone who needed to use the hallway as an exit for an emergency. Any items left of the hall were placed on the same side of the hall so as not to impede any necessary traffic. Completion date 11/02/22. c. Two staff members walked the G Hall, entered all resident rooms on that hallway searching for any residents. There were no residents found in any of the rooms or in the hallway. Completion date 11/02/22. d. A consultant and facility maintenance supervisor audit all exit doors to ensure all doors have their magnetic strip release and doors open in order to exit the building. Completion date 11/02/22. (continued on next page)

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