STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115313	A. Building B. Wing	09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Brookhaven	3535 Ashton Woods Drive NE Atlanta, GA 30319

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40979 Based on observations, interviews, record review, and review of the facility policy titled, Occurrences, and review of the policy Reporting Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property the facility failed to protect one of eight sampled residents, R#1, from neglect by not making observations of R#1 throughout one shift during which time R#1 eloped from the facility undetected. The elopement of R#1 was not identified for 10.5 after the last documented observation. On September 27, 2021, it was determined the facility's noncompliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Administrator and Regional Nurse Consultant were informed of the Immediate Jeopardy (IJ) on September 27, 2021, at 11:48 a.m. The noncompliance related to the IJ was identified to have existed on September 18, 2021, when staff failed to determine that R#1 was missing from the facility for 10.5 hours, until a family member arrived to visit and the resident's elopement was discovered. The IJ is outlined as follows: R#1 was a [AGE] year-old female admitted to the facility on [DATE], after a prolonged hospital stay, with diagnoses to include personal history of COVID-19, acute respiratory failure with hypoxia, multiple myeloma, and cognitive communication deficit. On 9/18/2021 at 10:30 a.m., the Responsible Party (RP) of R#1 arrived at the facility to visit the resident, prompted by their inability to reach the resident on her mobile phone earlier that morning. When they arrived, Licensed Practical Nurse (LPN) AA informed them that R#1 was missing from the facility. Review of the surveillance video, timestamped at 3:30 a.m. on 9/18/21, revealed R#1 leaving her room with her baggage and then disappeared from the camera view. At 3:38 a.m., R#1 was seen outside the facility walking down the driveway from the back of the facility towards the street. Interviews with LPN AA and Certified Nursing Assistant (CNA) BB revealed neither actually saw R#1 on 9/18/2021 on the Day Shift, 7:00 a.m. to 7:00 p.m. (7A-7P) and were not aware she was missing from the facility until the resident's family arrived to visit at 10:30 a.m. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews with CNA DD and Registered Nurse (RN) CC, who worked the Night Shift, 7:00 p.m. to 7:00 a.m. (7P-7A) revealed CNA DD never saw R#1 after 12:00 a.m. on 9/18/2021 and RN CC revealed she arrived late for her shift and never saw R#1 during her work hours of 12:33 a.m. until 6:58 a.m. on 9/18/2021, even though RN CC signed off as giving the resident's 6:00 a.m. medications which were left on the resident's bedside table. Interview with the assigned Detective from the local police precinct revealed the police located R#1 between 2:30 p.m.-3:00 p.m. on 9/18/21 at a local hotel approximately four miles from the facility. She was unharmed and declined medical attention. There was no evidence any facility staff observed R#1 or identified that R#1 was missing from the facility for 10.5 hours. The IJ was related to the facility's noncompliance with program requirements as follows: 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation (F 600, Scope and Severity (S/S): J) 42 CFR 483.25 Quality of Care (F 689, S/S: J) Additionally, Substandard Quality of Care was identified with requirements at 42 CFR 483.12, Freedom from Abuse, Neglect, and Exploitation (F 600, S/S: J) and 42 CFR 483.25, Quality of Care (F 689, S/S: J) An acceptable IJ Removal Plan was received on 9/28/2021. Based on observation, clinical record review, review of facility policies as outlined in the IJ Removal Plan, and staff interviews, it was validated that the corrective plans and the immediacy of the deficient practice was removed on 9/28/2021. The facility remained out of compliance while the facility continued management level oversight for neglect and to prevent further elopement and the staff conformance with the facility's policies and procedure. Findings include: Review of Occurrences policy effective 7/1/12, last reviewed 9/9/19 revealed the center recognizes that due to the frailty of the patients/residents served, there is an increased risk of occurrences that may result in injury to the patient/resident and/or others. In an effort to prevent occurrences, each patient/resident will be observed and assessed for risks. Appropriate, realistic interventions will be implemented in accordance to (sic) their plan of care. Further review revealed occurrence hazards are physical features in the healthcare center environment which may pose a risk to a patient/resident's safety, including but not limited to: (1) any event, accident, or incident, on or off healthcare center property which results in an injury or has the potential for injury. (2) Medication discrepancy and adverse drug reaction. (3) Unexplained injury to a patient/resident where no specific or actual incident was observed; yet the patient/resident exhibits evidence of an injury, such as a bruise or skin tear. (4) complaint of mental or physical abuse or neglect or witnessed abuse or neglect (abuse and/or neglect may be inflected by family, visitors, other patients/residents or staff). (5) elopement from healthcare center property regardless of whether or not there was an injury with the elopement. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Reporting Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property policy effective 12/1/01, last reviewed 7/29/19 revealed any allegation, suspicion or identified occurrence is identified involving patient abuse, neglect, exploitation, mistreatment, and misappropriation of property, including injuries of an unknown source, should be immediately reported to the Administrator of the provider entity. Notwithstanding anything contained in this policy to the contrary, in any case in which there is a reasonable suspicion that a crime has been committed against a patient of a Health Care Center, in addition to reporting to the appropriate state agency (or agencies) the incident should be reported to local law enforcement within 24 hours after forming the suspicion. Review of the Facility Incident Report Form, dated 9/18/2021, documented the elopement was identified at 11:15 a.m. and reported to the State Survey Agency (SSA) at 1:15 p.m. The final Facility Incident Report, dated 9/19/2021 revealed a thorough investigation and appropriate interventions, including staff education related to elopement protocol, identifying behaviors related to potential elopement, staff attendance, resident rounds, and medication administration. Record review revealed that R#1 was a [AGE] year-old female admitted to the facility on [DATE], from a prolonged hospital stay, with diagnoses to include acute respiratory failure with hypoxia, personal history of Covid-19, 2019-nCoV acute respiratory disease, cognitive communication deficit, and multiple myeloma. Review of the Minimum Data Set (MDS) Assessment revealed an Admission assessment was not completed. The Discharge Assessment for R#1 dated 9/18/2021 revealed the following: Short-term memory was okay; she was independent for daily decision-making skills, had a Mood score of zero indicating no depression, displayed no behaviors, independent for eating, bed mobility; required supervision for transfers, walking in room/corridor, locomotion on/off unit, dressing, toilet use, bathing; required limited assistance for personal hygiene, always continent of bladder/bowel, no unhealed pressure ulcers, and antibiotic medication. Review of the Progress Notes dated 9/17/2021 at 4:43 p.m. revealed the Responsible Party (RP) called the Unit Manager to request an early discharge with home health because the RP did not like that her family member had to be in quarantine for 14 days. Review of the Progress Notes dated 9/18/2021 at 11:15 a.m. (recorded as a late entry on 9/20/2021, 11:23 a.m. by the DON) revealed the Administrator was informed of R#1's elopement at approximately 11:15 a.m. Facility was searched inside and outside until the police arrived and searched off the property. Family was already at the facility. Law enforcement located R#1 later in the day at a local hotel. She was unharmed and uninjured. Facility considers resident discharged against medical advice (AMA). The Administrator attempted to contact the RP or follow-up with R#1 to ensure all needs were met but got no response. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Police Report dated 9/18/21 at 11:04 a.m. revealed that when the officer arrived at the facility, he met with the family member and Licensed Practical Nurse (LPN) AA at the entrance to the facility. The family member advised that elderly female was suffering from early dementia and that LPN AA was assigned to care for the resident (R#1). The family member stated her last contact with R#1 was the day before at 18:30 (6:30 p.m.) and that the resident had expressed a desire to leave the facility although the facility had advised to wait until Monday, 9/20/21. The family member stated coming to the facility to visit R#1 today (9/18/21) at 10:30 a.m. and when she came to the front desk of the facility, she was advised by staff that they were looking for R#1. Shortly after the facility staff stated they were unable to find the resident. LPN AA stated she checked for R#1 in her room around 8:30 a.m. to provide medication but the resident was not in her room. LPN AA stated she made a second attempt just before 11:00 a.m. although the resident still was not in her room. Staff advised that the facility has cameras, but the facility Administrator is the only person with access and was reviewing from her home. The police asked the Administrator to come to the facility to allow the police to review the cameras with her. The Administrator arrived at the facility at approximately 12:15 p.m. A passerby alerted the police of some clothing, bags and a purse at the southern end of the facility driveway. The family confirmed they belonged to the R#1. Further review of the Police Report revealed a lengthy review of the facility surveillance, it was determined that R#1 had left the facility through a window in room [ROOM NUMBER] at approximately 3:32 a.m. on 9/18/21 then traveled on foot out of sight to the southern end of the property. Through a series of investigative actions R#1 was tracked to a hotel in a surrounding city and the family was informed. Review of the Daily Schedule for 9/17/21 revealed that two nurses were assigned to the Transitional Care Unit (TCU) where the R#1 was located for the 7:00 p.m. to 7:00 a.m. shift, LPN EE and Registered Nurse (RN) CC. Review of the timecard punch details for 9/17/21 and 9/18/21 revealed that RN CC clocked in at 0.33 (12:33 a.m.) on 9/18/21 and clocked out on 9/18/21 at 6:58 a.m. LPN AA clocked in on 9/18/21 at 8:38 a.m. and clocked out at 20:13 (8:13 p.m.). Review of the Medication Administration Record (MAR) for R#1 revealed she was scheduled for Ondansetron 8 milligrams (mg) and Pantoprazole 40 mg at 6:00 a.m. both were signed as given by RN CC although per the police report and surveillance cameras the resident had eloped from the facility at 3:30 a.m. Review of the facility staff investigation statements revealed that RN CC on 9/18/21 during 6:00 a.m. med pass, she thought the resident was in the bathroom and it was not unusual for the resident to be out of bed since she was independent for ambulation. Unfortunately, I made a mistake and did not physically lay eyes on her during my morning rounds. Further review revealed that CNA DD's written statement stated she checked on the resident on 9/18/21 at 12:00 a.m., 4:00 a.m., and 7:00 a.m. and that was the last time she saw the resident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with Maintenance Director (MD1) on 9/22/21 at 10:00 a.m. revealed he has worked at the facility for 5 years and currently works 7 days a week. The MD1 further revealed that he has been at the facility since the recent elopement of R#1 to ensure the security of the exit doors and all windows to prevent additional elopements. He further revealed that he discovered the resident escaped through a window in room [ROOM NUMBER] and that the resident climbed out of the window on 9/18/21 by lifting the base of the window seal in order to climb out the window. MD1 stated he did see the window screen on the ground outside the window on 9/18/21. He continued to state that he has been working to test the exit doors to ensure they currently work, as well as, reinforcing all windows with two nails (one at the top of the window seal and one at the bottom of the window seal) to prevent residents from forcing the window open. He continued to state windows can be forced open in the event of an emergency by facility staff or emergency personnel. An interview with Certified Nursing Assistant (CNA) BB on 9/22/21 at 2:30 p.m. revealed she was working at the facility from 7:00 p.m. Friday, 9/17/21 to 11:00 a.m. Saturday 9/18/21. She further revealed first seeing R#1 on 9/17/21 at approximately 7:15 p.m. during shift change when she was counting all residents present on the Transitional Care Unit (TCU). She further revealed seeing the resident at this time in her room, sitting on her bed with her back facing the door. She further revealed that she did not see the resident again during her shift although she was not assigned the resident's room. CNA BB revealed that she did stay late to assist in passing out the breakfast trays to the residents on TCU on Saturday 9/18/21 morning (CNA BB was unsure of the time). CNA BB further revealed that the resident was not in her room when she brought the breakfast tray into her room although she assumed the resident was nearby because she was able to self-ambulate and left the tray for her return. CNA BB confirmed not returning to the resident's room to collect the tray or to check if she had eaten her meal. An interview with Licensed Practical Nurse (LPN) AA on 9/22/21 at 2:50 p.m. revealed she did not work at the facility on Friday 9/17/21. She stated she was scheduled to work at the facility on Saturday 9/18/21 from 7:00 a.m. to 7:00 p.m. but she was late and did not report to work until 8:30 a.m. LPN AA stated she was scheduled to relieve RN CC who was scheduled to work 7:00 p.m. to 7:00 a.m. and when she arrived to work RN CC had already left and did not leave a report concerning the residents on Transitional Care Unit (TCU). She continued to state when she reported to work, she noticed R#1's family in the lobby but did not know at the time there was a potential issue until she arrived on TCU and went to R#1's room and noticed she was not present. She continued to state when she arrived at R#1's room she noticed all her personal belongings were gone, her breakfast tray was on her table tray untouched and there was a clear, medication cup with two pills, Zofran (Ondansetron) and Pantoprazole, in the medication cup on her breakfast tray. She continued to say she did not touch anything in R#1's room and began the search to locate R#1. LPN AA stated it was after 9:00 a.m. when she noticed R#1 was not in her room. LPN AA did not call a Code Pink (code to alert the staff a resident is missing and to begin a search) or inform the Unit Manager on duty until after R#1's family arrived. She stated when she realized R#1 was not in the building she called DHS at approximately 11:10 a.m., the Administrator at approximately 11:15 a.m. and the Unit Supervisor (US) after speaking with the Administrator to advise them of the missing resident then went to the lobby to inform R#1's family that she was missing. LPN AA stated after informing R#1's family of her status she then called 911 to get the local police involved. She continued to state there was no weekend supervisor on duty in the building on Saturday. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with LPN FF on 9/22/21 at 3:20 p.m. revealed she worked at the facility on Saturday 9/18/21 from 7:00 a.m. to 7:00 p.m. She continued to state she was responsible for caring for the residents in rooms 200 through 211 and LPN EE was responsible for caring for the residents in rooms 216 through 232. LPN FF stated when she reported to work, she received hand-off report from LPN EE with regards to any issues or concerns for the residents in the Transitional Care Unit (TSU). She continued to state that his report included the residents on her hall because RN CC left before she arrived and was not available to do hand-off and give report on residents. LPN FF continued to state she was familiar with R#1 but had little interaction with her. She continued to state when she did have the opportunity to speak to R#1 she never expressed wanting to go home or plans to go home. She stated R#1 was always pleasant and made her needs known, she would ambulate and was independent in toileting. An interview with CNA HH on 9/22/21 at 4:30 p.m. revealed she has worked at the facility on Friday 9/17/21 from 7:00 a.m. to 7:00 p.m. but worked until 11:00 p.m. to assist on the Transitional Care Unit (TCU) but did not work on 9/18/21. CNA HH revealed that she was assigned to residents in rooms 200 through 208. She further revealed that the residents in room [ROOM NUMBER] were moved from that room earlier in the day due to the end of the duration of their quarantine. She revealed this room was empty at this time and was the room that R#1 eloped. CNA HH further revealed that she was familiar with R#1 and recalled her to be quiet, kept to herself, she took her medication well, she ate her meals and did not complain about anything. CNA HH stated she did not interact with R#1 on Friday during her shift. An interview with CNA II on 9/22/21 at 4:40 p.m. revealed she worked at the facility on Friday 9/17/21 from 7:00 a.m. to 7:00 p.m. and did not work on 9/18/21. CNA II revealed being assigned to the R#1 and did recall seeing her in her room during her shift when she went back to her room to pick up her dinner tray approximately between 6:00 p.m. and 6:30 p.m. She further revealed that R#1 was sitting on her bed and did not respond to cues to talk when CNA asked how she was doing or if she needed anything. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview with RN CC on 9/23/21 at 11:50 a.m. revealed she worked at the facility on Saturday, 9/18/21, from 12:00 a.m. to 7:00 a.m. She confirmed that she was scheduled to work from 7:00 p.m. to 7:00 a.m. on Friday 9/17/21 and Saturday 9/18/21 but she called out on Friday 9/17/21 and reported late (12:33 a.m.) to work on Saturday 9/18/21. RN CC revealed that when she arrived to work on 9/18/21, that LPN EE was the only nurse on the floor, and was working alone. She stated she could see LPN EE was behind in passing medications to the residents therefore she began passing medications (med pass) as soon as she arrived. RN CC stated she started with room [ROOM NUMBER] and passed meds to only a few residents but could not remember them all. She stated one of the rooms she entered to pass medications was R#1's room although the resident was not present at this time during the med pass. She further revealed that after passing medications she sat down at the nurses' station and began charting (update residents medical records with current activity performed by the nurse who enters documentation). RN CC revealed that she did not go back into R#1's room until 6:00 a.m. to administer her medication. She further revealed that she did not see R#1 in her bed or in her room. RN CC revealed that R#1's bathroom light was on, the door was slightly open, and she thought she heard water running therefore, she thought R#1 was in the bathroom. RN CC stated because she thought R#1 was in her bathroom she put her medication cup on her breakfast tray that was sitting on her table tray untouched. She continued to state after placing R#1's medication cup down on the breakfast tray, unattended, she continued with the medication pass on the unit. RN CC further stated it was normal and routine for her to leave R#1's medication for her to take on her own and she does not stay to witness R#1 taking her medication because she is very independent. RN CC revealed that LPN EE administered medication, and that she charted giving the medications, although she wasn't in the facility. RN CC continued to confirm she could not verify when the vitals were actually taken although she documented she was present and had taken R#1's vital information. RN CC further stated that at the end of her shift on Saturday 9/18/21 that LPN EE helped her count the narcotic drawer. She continued to state that when she clocked out for the day she did not wait for the on-coming nurse, LPN AA. RN CC stated she started to receive phone calls from the DHS, LPN EE, and CNA JJ regarding R#1. She revealed receiving phone calls asking when the last time was she saw R#1 and if she actually saw the resident when she administered medication pass which she reported the last time she saw R#1 was at midnight. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with the Administrator on 9/22/21 at 5:23 p.m. revealed she received a call on 9/18/21 at approximately 11:15 a.m. from Guest Services Manager (GSM), to advise a Code Pink (missing/eloped resident) has been called at the facility. She stated she began to question GSM as to the resident's name and room number, then gave instructions to search the entire facility twice, if resident is not found to expand the search to the outside grounds around the building, and if resident was not found outside to call 911 immediately. She further revealed that after phone call with GSM she checked her facility computer at home and then contacted the police department were the resident lived and ask for a welfare check after explaining the situation. The Administrator revealed that the local police department had responded to the facility, and she was advised that detectives will be taking over the investigation and will be onsite shortly. The Administrator stated she arrived at the facility at approximately noon on 9/18/21. When the Administrator arrived at the facility the family of R#1's was already present, talking with police officers and engaged in the search for R#1. The Administrator further revealed that she shared facility camera footage of the early morning hours with R#1's family which indicates R#1 was outside walking on the side of the building through the alley at 3:38 a.m. on 9/18/21. Review of the surveillance camera video revealed that the resident exited her room, walked down the hallway and entered room [ROOM NUMBER], which at the time was empty, and dislodged the base of the window in order to push the window open and remove the screen so she could climb out of the window with her personal belongings and leave the facility. The Administrator revealed that the Corporate Nurse Consultant (NC) arrived at the facility on 9/18/21, cannot recall time, and a head count of remaining residents on TSU and instructed maintenance to check all doors and windows for security. The Administrator revealed that phone calls were being made to the area hospitals for any recent admissions that fit R#1s description although no one fit the description. The Administrator revealed that R#1's purse and clothing were found in the trees and bushes just outside the facility property, but R#1's wallet and cell phone were missing among her personal items. The Administrator further stated the family and facility tried continuously to reach R#1 by phone until approximately 4:30 p.m. when it was determined the phone was turned off. The Administrator revealed that the Detectives advised the family to check the resident's bank records to determine if the resident had used her credit card. The family was able to gain access to R#1's bank account and was able to determine that R#1's credit card had been used at a drug store and a local hotel. The Detective contacted her stating the resident had been located and is safe and with her family. The Administrator further revealed that the investigation determined that CNA DD was the last person to see the resident and that RN CC charted giving medications to R#1 but did not and did not attempt to locate the resident. The Administrator revealed that RN CC should have waited for LPN AA to give report and that the Administrator was not aware that RN CC had been 5.5 hours late for her shift. An interview with Director of Health Services (DHS) on 9/22/21 at 5:52 p.m. revealed she did not work at the facility on Friday 9/17/21 and was called to come to the facility by the Administrator on Saturday 9/18/21 due to the circumstances taking place regarding the missing resident. The DHS revealed that all nursing staff should stay on duty until the on-coming nurse arrives and a proper resident review and hand-off is completed. She further revealed that the nurses did not follow policy or nursing standards on 9/17/21 through 9/18/21. The DHS revealed that it is unacceptable for any nurse to leave any type or kind of medication unattended with the expectation that the resident who it is intended for will see it and take their medication. She continued to state she would expect the nurse who dispensed the medication to keep the medicine with her until the resident is available to take the medication and to return later to give the medications. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with LPN EE on 9/22/21 at 7:04 p.m. revealed he worked at the facility on Friday 9/17/21 from 7:00 p.m. to 7:00 a.m. and on Saturday 9/18/21 from 7:00 p.m. to 7:00 a.m. He stated he was responsible for caring for the residents in rooms 214 through 232. LPN EE further revealed that he was working with CNA JJ and DD on 9/17/21 and that CNA DD was assigned to R#1. A telephone interview with CNA JJ on 9/23/21 at 9:35 a.m. revealed she did not work at the facility on Friday 9/17/21 but she did work at the facility on Saturday 9/18/21 from 7:00 a.m. to 3:00 p.m. CNA JJ stated after reporting to work Saturday morning she began to pass breakfast trays at approximately 7:15 a.m. and that CNA BB was responsible for passing breakfast trays for her residents that included R#1. CNA JJ further revealed that LPN AA reported to work late on 9/18/21 and reported to the facility at approximately 9:45 a.m. At approximately 10:00 a.m. she overheard LPN AA talking with LPN FF telling her that the family for R#1 was at the front desk and want to see her, but she is not in her room. CNA JJ revealed that staff began to look for the resident at that time. CNA JJ revealed that she went to R#1's room and noticed her breakfast tray on her tray table had been untouched. CNA JJ stated she asked CNA BB if she saw R#1 when she brought her breakfast tray to her room and CNA BB replied, no. A telephone interview with LPN KK, Unit Supervisor, on 9/23/21 at 9:45 a.m. revealed she was at the facility on Friday 9/17/21 and worked from 7:00 a.m. to 7:00 p.m. although she did not work on 9/18/21. LPN KK revealed being familiar with R#1 and that the resident did not like to be in isolation, was very alert, and cooperative in taking medication. She continued to state during her interactions with R#1 she never displayed signs and never voiced wanting to leave the facility. LPN KK stated she encountered R#1 twice during her shift on Friday, the first time the resident came to the Nurses' Station at approximately 3:00 p.m. without her oxygen on. LPN KK redirected the resident to her room and explained she could not be out of her room due to isolation status. She further revealed she last saw R#1 on Friday at approximately 4:30 p.m. during medication pass and she witnessed R#1 take her medication at that time. A telephone interview with LPN LL on 9/23/21 at 10:25 a.m. revealed she was at the facility on Friday 9/17/21 and worked from 7:00 a.m. to 7:00 p.m. and again on Saturday 9/18/21 from 7:00 p.m. to 7:00 a.m. She further revealed that although she did not personally care for R#1 she was familiar with her and on two occasions witnessed R#1 walk out of her room on Friday afternoon at approximately 3:00 p.m. without her oxygen and without her mask on. LPN LL further revealed that the second occasion she witnessed R#1 out of her room and walk to the nurse's station and staff redirected her back to her room and explained to R#1 she could not be out of her room due to her isolation status. LPN LL continued to state on the few occasions she interacted with R#1 she did not express wanting to go home or that she was being discharged . (continued on next page)

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	115313	A. Building B. Wing	09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Brookhaven	3535 Ashton Woods Drive NE Atlanta, GA 30319

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview with CNA DD on 9/23/21 at 12:36 p.m. revealed that she worked at the facility on Friday 9/17/21 from 7:00 p.m. to 7:00 a.m. although she arrived late, 7:33 p.m., for her shift and was assigned to R#1. CNA DD further revealed that R#1 was independent and could ambulate independently. She revealed that she did see resident in her room during her rounds on Friday 9/17/21 at 8:00 p.m. and 10:00 p.m., then again on Saturday 9/18/21 at 12:00 a.m. during her shift. CNA DD stated when she made her rounds again at 2:00 a.m. and she entered R#1's room she was not in her bed. She further revealed notifying RN CC that the resident was not in her room at 2:00 a.m. and then took her thirty-minute break. CNA DD further revealed that she could not find the resident at 3:00 a.m. and reported this to RN CC. CNA DD revealed that she went back to R#1's room for the last time at 7:00 a.m. to double check and see if she was back in her room and she was not. She stated receiving a call from LPN EE at 9:00 a.m. asking her when she last saw R#1 and she reported that she last saw R#1 at 12:00 a.m. Saturday 9/18/21 morning. CNA DD continued to state she did not give oral report to on-coming CNA before she left the facility at 7:00 a. m. An interview with Staffing Coordinator (SC) on 9/23/21 at 5:52 p.m. revealed the facility policy for Call Outs and Late Arrivals is that employees are required to notify the staffing coordinator at least two hours or as soon as possible, in advance of their scheduled time to start their shift. She continued to state employees are considered late if they clock-in 5 minutes after their scheduled shift start time. SC stated on Friday 9/17/21 she called CNA DD to ask where she was and why she has not reported to work yet. She further revealed that CNA DD informed her that she was on her way. SC stated CNA DD arrived to work at 7:30 p.m. and was scheduled to report at 7:00 p.m. SC further revealed that RN CC did not call SC to advise she was going to be late on Friday 9/17/21 and DHS did not communicate this information either. SC revealed that LPN EE did not call SC to advise he was going to be late on Friday 9/17/21 nor did LPN AA call to say she would be late on Saturday 9/18/21. She revealed that the DHS was not notified by either nurse. The Facility implemented the following actions to remove the IJ: 1. On 9/18/21 by utilizing a current facility census a visual full facility Head Count Audit was conducted, and all other residents were accounted for. 2. On 9/18/21, Nurse Consultant provided education on frequent rounding standard of practice and abuse policy as it relates to neglect for all nursing staff and medication administration for all nurses and to be completed prior to staff working thereafter. As of 9/27/21, sixty-three (63), or ninety-six (96) percent of licensed and certified nursing staff had received this in-service training. As of 9/27/21, twelve (12) or one hundred (100) percent of the facility's Registered Nurses, had receive this in-service training. As of 9/27/21, nineteen (19) or ninety-five (95) of the facility's twenty (20) Licensed Practical Nurses had received this in-service training. As of 9/27/21, thirty (30) or ninety-seven (97) percent of the facility's thirty-one (31) Certified Nursing Aides had received this in-service training. The remaining two (2), staff who were unavailable for training at that time due to being one (1) being off-duty and one (1) on leave, were to receive this in-service training upon their return to work; these licensed staff would not be allowed to provide direct resident care until completion of this in-service. Administrator and/or Director of Nursing will continue training until all necessary staff have been trained. Refer to #12 for auditing tool. 3. On 9/18/21, Nurse Consultant provided education on medication administration, specifically as it relates t [TRUNCATED]

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38154 Based on staff interviews, clinical record review, and reviews of the facility policy titled, Medication Administration: General Guidelines, and the Georgia Nurse Practice Act, Chapter 410-10 Standards of Practice and Unprofessional Conduct, Rules 410-10-.01 through .03, the facility failed to follow facility policy and acceptable nursing standards regarding medication administration. Specifically, Registered Nurse (RN) CC left two (2) medications at the bedside when one (1) resident (R)#1 was unavailable. In addition, RN CC documented three (3) medications as administered during times when she was not on duty. The sample size was eight (8) residents. Findings include: Review of the facility policy titled, Medication Administration: General Guidelines, reviewed 3/23/2021, revealed the following: Procedures: 4. Medications are administered at the time they are prepared. 7. Patients/residents are identified before medication is administered. 11. After medication administration for facilities utilizing electronic MAR [Medication Administration Record], the patient/resident's [electronic] eMAR is electronically signed off. 13. If a dose or regularly scheduled medication is withheld, refused, or given at other than the scheduled time .for facilities utilizing the eMAR system, the NOT ADMINISTERED button will be utilized with the appropriate reason given for not administering medication at the scheduled time. An explanatory note is entered .for the eMAR the note can be typed into the appropriate space provided within the electronic system. 15. For patients/residents not in their rooms or otherwise unavailable to receive medication on the pass .the eMAR is not marked as ADMINISTERED until medication is given to the patient/resident. After the medication pass, the nurse returns to the missed patient/resident to administer the medication. Rules 410-10-.01, Standards of Practice for Registered Nurses: (2) The Board (Georgia Board of Nursing) recognizes that assessment, nursing diagnosis, planning, intervention, evaluation, teaching, and supervision are the major responsibilities of the registered nurse in the practice of nursing. The Standards of Practice for Registered Professional Nurses delineate the quality of nursing care which a patient/client should receive regardless of whether solely by a registered nurse or in collaboration with other licensed or unlicensed personnel. The Standards of Practice for Registered Professional Nurses shall establish a baseline for quality nursing care; be derived from the Georgia Nurse Practice Act; apply to the registered nurse practicing in any setting; and govern the practice of the licensee at all levels of competency. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Rules 410-10-.03, Definition of Unprofessional Conduct revealed the following: (1) Nursing conduct failing to meet the minimal standards of acceptable and prevailing nursing practice, which could jeopardize the health, safety, and welfare of the public, shall constitute unprofessional conduct. This conduct shall include, but not be limited to, the following: (2) Practice (e) Abandoning or knowingly neglecting patients/clients requiring nursing care; (o) Providing information, which was false, deceptive, or misleading in connection with the practice of nursing; (3) Documentation (a) Failing to maintain a patient record that accurately reflects the nursing assessment, care, treatment, and other nursing services provided to the patient; Review of the clinical record revealed R#1 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include acute respiratory failure with hypoxia, personal history of Covid-19, 2019-nCoV acute respiratory disease, cognitive communication deficit, and multiple myeloma. Review of the Facility Incident Report Form dated 9/18/2021 revealed R#1 eloped from the facility at 3:30 a.m. on 9/18/2021. An interview with Licensed Practical Nurse (LPN) AA on 9/22/2021 at 2:50 p.m., she stated she was scheduled to work on Saturday, 9/18/2021, 7:00 a.m. to 7:00 p.m. (7A-7P/Day Shift) shift, however she was late and did not report to work until 8:33 a.m. LPN AA stated she was supposed to relieve Registered Nurse (RN) CC who worked the 7:00 p.m. to 7:00 a.m. (7P-7A/Night Shift) shift but RN CC had already left and did not leave a report concerning the residents on the 200 Hall. She stated she determined sometime after 9:00 a.m. that R#1 was not in her room, her belongings were gone, and her breakfast tray was on the bedside table was untouched along with two (2) pills in a cup which she determined were Zofran (for nausea) and pantoprazole (for gastroesophageal reflux disease-GERD). She stated she did not touch anything in the room and began to search for R#1 around the facility. She stated she was called to the front desk about 10:30 a.m. where R#1's daughter and granddaughter were waiting to visit R#1 and she informed them R#1 was missing from the facility. She stated she informed the Manager on Duty who was the Guest Services Manager (GSM) who she called the Administrator and the Director of Health Services (DHS). She stated the Administrator instructed her to call the local police and get the staff to help continue the search for R#1. Review of the surveillance video on 9/21/2021 at 12:55 p.m. from surveillance on 9/18/2021, 3:30 a.m. through 3:45 a.m. revealed R#1 exited her room with her baggage at 3:30 a.m. and was seen again on video at 3:38 a.m. outside the facility in the driveway walking away from the facility. Review of the eMAR for R#1 revealed ondansetron (Zofran) 8 milligrams (mg) tablet ordered every eight (8) hours and pantoprazole 40 mg tablet ordered every morning were both scheduled at 6:00 a.m. and both medications were signed off as administered as evidenced by the initials of RN CC on 9/18/2021 at 6:00 a.m. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Continued review of the eMAR revealed RN CC signed off on medications at times when she was not on duty. a. acyclovir: 400 mg orally, ordered twice daily, was initialed by RN CC on 9/17/2021 at 9:00 p.m. b. melatonin: 3 mg tablet; administer 6 mg orally at bedtime/scheduled for 9:00 p.m. and initialed by RN CC on 9/17/2021 at 9:00 p.m. c. ondansetron: 8 mg tablet, orally, ordered every eight (8) hours/scheduled at 10:00 p.m., was initialed by RN CC. An interview with LPN EE on 9/22/2021 at 7:05 p.m. revealed that he worked Friday, 9/17/2021, 7:00 p.m. to 7:00 a.m. and was assigned to rooms 214-232. He stated CNA DD and CNA JJ were assigned to the unit and RN CC called to say she would be late to work. He stated R#1 was pleasant, quiet, didn't need much help, took her meds well, and had a cordial relationship with her roommate. He stated the normal protocol for med pass if resident is not available is to check the bathroom and try to locate the resident. He stated he would hold the meds and return them to the medication cart if the resident was unavailable. He stated the urgency to locate a resident would depend on the medication due at the time, such as insulin. He stated his initials, in parentheses, on the Medication Administration Record (MAR) meant he made a note regarding the medication not given, such as when a resident is transferred to the hospital or on leave of absence (LOA). He revealed that the medications will continue to show on the eMAR until the medication is removed from the active eMAR. Finally, he stated he did not administer medications to R#1 on his shift. A telephone interview with Registered Nurse (RN) CC on 9/23/2021 at 11:50 a.m., revealed that she arrived to work after midnight on 9/18/2021. She confirmed not informing the Staff Development Coordinator of her planned late arrival but called the LPN EE. She further revealed that when she got to work that LPN EE was the only nurse on the unit, had already assessed R#1 and given any medications due. She revealed signing off on the medications already given at 9:00 p.m. and the assessments already done to catch up on the charting since she had been late to work. She revealed knowing that R#1 to be alert and oriented, able to make her needs known, and able to ambulate and toilet herself without assistance so she was not worried about her throughout the shift. She stated she dispensed the 6:00 a.m. medications due, the names of which she could not recall, and entered R#1's room but did not see her. She stated she assumed R#1 was in the bathroom because the door was ajar, the light was on, and she thought she heard water running. She revealed that she did not call out to R#1 to confirm she was in the bathroom but simply left the medications on the bedside table for R#1 to take when she came out of the bathroom. She confirmed she did not actually see R#1 during the hours she worked. She revealed clocking out at about 7:00 a.m. and did not wait for the oncoming nurse because she did not feel well. She stated she was not aware R#1 had eloped from the facility until LPN EE called her later that Saturday morning on 9/18/2021. Review of the Punch Detail Dataview revealed RN CC clocked in on 9/18/2021 at 00:33 (12:33 a.m.) and clocked out on 9/18/2021 at 06:58 (6:58 a.m.). In addition, LPN AA clocked in on 9/18/2021 at 08:38 (8:38 a.m.). In an interview with the Regional Nurse Consultant (RNC) on 9/23/2021 at 11:00 a.m., revealed that she became aware of the discrepancies in documentation for RN CC for 9/17/2021 through 9/18/2021 while investigating the elopement of R#1 but had not completed that investigation. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Director of Health Services (DHS) on 9/30/2021 at 7:23 p.m., revealed that she expected the nursing staff to follow accepted nursing standards of care and facility policies/protocols of making resident rounds with shift report, perform the narcotics count, and account for every resident, make resident rounds every two hours, and nurses should be assisting with activities of daily living (ADLs). She revealed that staff should call-out or call-late to their direct supervisor or DHS, and outgoing staff should wait for their relief before leaving the facility. Staff should reach out to their DHS when overwhelmed due to circumstances out of their control or they cannot wait for relief staff to arrive. She stated medications should not be pulled/dispensed before seeing the residents; no medication should be left at the bedside because this is not a self-medicating facility. In addition, she stated Management is looking to relocate the Observation Unit and staff will be designated to care for those residents. In an interview with the Administrator on 9/30/2021 at 7:32 p.m., she stated the Corporate Office was pursuing solutions to staffing challenges such as contracting with foreign countries to provide nursing care. She stated the elopement of R#1 was her first since she assumed her position and believes her team has placed sufficient interventions to prevent any future potential elopements. In addition, she stated she expected all staff to adhere to all facility policies and protocols of competent resident care and service and to alert their managers or herself if/when those standards cannot be met. Finally, she stated RN CC was terminated on 9/27/2021 for failure to follow RN standards of practice and inaccurately documenting medication administration on 9/17/2021. Review of the Separation Notice for RN CC dated 9/27/21 for failure to follow RN Standards of Practice and for inaccurately documenting medication administration on 9/17/21.

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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** 38154 Based on family, staff, and law enforcement interviews; record review; and review of facility policy titled, Occurrences, the facility failed to provide supervision and monitoring to prevent the elopement of one resident (R) #1 from a sample of eight (8) residents. Staff did not actually observe R#1 in the facility for 10.5 hours, during which time she eloped from the facility. R#1 was located approximately four (4) miles from the facility. R#1 was found unharmed but the potential for harm met the level of Immediate Jeopardy. On September 27, 2021, it was determined the facility's noncompliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Administrator and Regional Nurse Consultant were informed of the Immediate Jeopardy (IJ) on September 27, 2021, at 11:48 a.m. The noncompliance related to the IJ was identified to have existed on September 18, 2021, when staff failed to determine that R#1 was missing from the facility for 10.5 hours, until a family member arrived to visit and the resident's elopement was discovered. The IJ is outlined as follows: R#1 was a [AGE] year-old female admitted to the facility on [DATE], after a prolonged hospital stay, with diagnoses to include personal history of COVID-19, acute respiratory failure with hypoxia, multiple myeloma, and cognitive communication deficit. On 9/18/2021 at 10:30 a.m., the Responsible Party (RP) of R#1 arrived at the facility to visit the resident, prompted by their inability to reach the resident on her mobile phone earlier that morning. When they arrived, Licensed Practical Nurse (LPN) AA informed them that R#1 was missing from the facility. Review of the surveillance video, timestamped at 3:30 a.m. on 9/18/21, revealed R#1 leaving her room with her baggage and then disappeared from the camera view. At 3:38 a.m., R#1 was seen outside the facility walking down the driveway from the back of the facility towards the street. Interviews with LPN AA and Certified Nursing Assistant (CNA) BB revealed neither actually saw R#1 on 9/18/2021 on the Day Shift, 7:00 a.m. to 7:00 p.m. (7A-7P) and were not aware she was missing from the facility until the resident's family arrived to visit at 10:30 a.m. Interviews with CNA DD and Registered Nurse (RN) CC, who worked the Night Shift, 7:00 p.m. to 7:00 a.m. (7P-7A) revealed CNA DD never saw R#1 after 12:00 a.m. on 9/18/2021 and RN CC revealed she arrived late for her shift and never saw R#1 during her work hours of 12:33 a.m. until 6:58 a.m. on 9/18/2021, even though RN CC signed off as giving the resident's 6:00 a.m. medications which were left on the resident's bedside table. (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 assigned Detective from the local police precinct revealed the police located R#1 between 2:30 p.m.-3:00 p.m. on 9/18/21 at a local hotel approximately four miles from the facility. She was unharmed and declined medical attention. There was no evidence any facility staff observed R#1 or identified that R#1 was missing from the facility for 10.5 hours. The IJ was related to the facility's noncompliance with program requirements as follows: 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation (F 600, Scope and Severity (S/S): J) 42 CFR 483.25 Quality of Care (F 689, S/S: J) Additionally, Substandard Quality of Care was identified with requirements at 42 CFR 483.12, Freedom from Abuse, Neglect, and Exploitation (F 600, S/S: J) and 42 CFR 483.25, Quality of Care (F 689, S/S: J) An acceptable IJ Removal Plan was received on 9/28/2021. Based on observation, clinical record review, review of facility policies as outlined in the IJ Removal Plan, and staff interviews, it was validated that the corrective plans and the immediacy of the deficient practice was removed on 9/28/2021. The facility remained out of compliance while the facility continued management level oversight for neglect and to prevent further elopement and the staff conformance with the facility's policies and procedure. Findings include: Review of the facility policy titled, Occurrences, last reviewed 9/9/2019, revealed the following: Definitions: Occurrence hazards are physical features in the healthcare center environment which may pose a risk to a patient/resident's safety, including but not limited to: Any event, accident or incident, on or off healthcare center property, which results in an injury or has the potential for injury . Elopement from healthcare center property regardless of whether or not there was an injury associated with the elopement. R#1 was a [AGE] year-old female admitted to the facility on [DATE], after a prolonged hospitalization , with diagnoses to include acute respiratory failure with hypoxia, personal history of Covid-19, 2019-nCoV acute respiratory disease, cognitive communication deficit, and multiple myeloma. Review of the Minimum Data Set (MDS) Assessment revealed an admission assessment was not completed. The Discharge Assessment for R#1 dated 9/18/2021 revealed the following: 1. Short-term memory was okay; she was independent for daily decision-making skills, had a Mood score of zero (0)-indicating no depression, displayed no behaviors (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Independent for eating, bed mobility; required supervision for transfers, walking in room/corridor, locomotion on/off unit, dressing, toilet use, bathing; required limited assistance for personal hygiene 3. Always continent of bladder/bowel 4. No unhealed pressure ulcers 5. Antibiotic medication Review of the Care Plan for R#1 dated 9/13/2021 revealed she was care planned for advanced directives, pain, fall risk, activities of daily living (ADL) functional/ rehabilitation potential, and discharge planning. Discharge planning goals were to begin discharge planning upon admission and to meet the initial goals of care and discharge. Interventions for discharge planning included promoting education to resident/family/caregiver as needed and involve resident, representative, and interdisciplinary team (IDT) in the discharge planning process. Review of the Progress Notes dated 9/17/2021 at 4:43 p.m. revealed the RP called the Unit Manager of the 200 Hall to request an early discharge with home health because she did not like that the resident had to be in quarantine for 14 days. Review of the Progress Notes dated 9/18/2021 at 11:15 a.m. (recorded as a late entry on 9/20/2021, 11:23 a.m. by the DHS) revealed the Administrator was informed of R#1's elopement at approximately 11:15 a.m. Facility was searched inside and outside until the police arrived and searched off the property. Family was already at the facility. Law enforcement located R#1 later in the day at a local hotel. She was unharmed and uninjured. Facility considers resident discharged against medical advice (AMA). Administrator attempted to contact the RP or follow-up with R#1 to ensure all needs were met but got no response. Review of the Facility Incident Report Form, dated 9/18/2021, documented the elopement was identified at 11:15 a.m. and reported to the State Survey Agency (SSA) at 1:15 p.m. The final Facility Incident Report, dated 9/19/2021 revealed a thorough investigation and appropriate interventions, including staff education related to elopement protocol, identifying behaviors related to potential elopement, staff attendance, resident rounds, and medication administration. Review of the Police Report and Investigation Notes dated 9/18/2021 revealed the local precinct received a report of elopement from the facility at 11:04 a.m. and arrived at the facility at 11:07 a.m. (continued on next page)

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	115313	A. Building B. Wing	09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Brookhaven	3535 Ashton Woods Drive NE Atlanta, GA 30319

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Police Report dated 9/18/21 at 11:04 a.m. revealed that when the officer arrived at the facility, he met with the family member and Licensed Practical Nurse (LPN) AA at the entrance to the facility. The family member advised that elderly female was suffering from early dementia and that LPN AA was assigned to care for the resident (R#1). The family member stated her last contact with R#1 was the day before at 18:30 (6:30 p.m.) and that the resident had expressed a desire to leave the facility although the facility had advised to wait until Monday, 9/20/21. The family member stated coming to the facility to visit R#1 today (9/18/21) at 10:30 a.m. and when she came to the front desk of the facility, she was advised by staff that they were looking for R#1. Shortly after the facility staff stated they were unable to find the resident. LPN AA stated she checked for R#1 in her room around 8:30 a.m. to provide medication but the resident was not in her room. LPN AA stated she made a second attempt just before 11:00 a.m. although the resident still was not in her room. Staff advised that the facility has cameras, but the facility Administrator is the only person with access and was reviewing from her home. The police asked the Administrator to come to the facility to allow the police to review the cameras with her. The Administrator arrived at the facility at approximately 12:15 p.m. A passerby alerted the police of some clothing, bags, and a purse at the southern end of the facility driveway. The family confirmed they belonged to the R#1. A telephone interview with the local police Detective on 9/21/2021 at 4:24 p.m., he stated his officers arrived at the facility on 9/18/2021 at 11:07 a.m. in response to a report of a missing nursing home resident and continued to search for R#1 outside the facility. He stated a passerby notified them of clothes/personal items left on the side of the road within the subdivision minus R#1's wallet and mobile phone. He stated he requested the Administrator come to the facility to view the surveillance video which showed R#1 leaving her room at 3:00 a.m. without oxygen or a face mask. She returned to her room and left the room again with her baggage at 3:30 a.m.; seen again on video at 3:38 a.m. outside the facility walking down the driveway away from the facility. He stated they determined R#1 left through a window in a vacant room [ROOM NUMBER] on her unit. He stated R#1 dislodged the window, removed the screen and climbed out of the window. He stated at 1:38 p.m., he and R#1's Responsible Party (RP) tracked R#1 via her bank card to a drug store approximately four (4) miles away in [NAME] Springs and then to a hotel near the drug store between 2:30 p.m.-3:00 p.m. He stated R#1 told him when she left the facility, she stayed in front of the nearby grocery store, 0.6 miles from the facility (14-minute walk), until it opened that morning at 7:30 a.m., having crossed three (3) lanes of traffic. He was not certain how R#1 got to [NAME] Springs, but she was not injured or harmed in any way. He stated R#1 told him she didn't want to wait until Monday for her scheduled discharge from the facility. He stated R#1 last spoke with her RP on Friday afternoon (9/17/2021) and based on that conversation, her RP daughter decided to discharge her R#1 on Sunday, 9/19/2021 instead, feeling her mother was getting restless. R#1's called several times on Saturday morning (9/18/2021) but was unable to contact the resident so the RP decided to go to the facility to check on the resident. He stated R#1 left her personal effects on the side of the road and strewn onto trees because they were too heavy to carry. He stated he tried to locate R#1 via her phone company but was unable as R#1 had either turned the phone off or turned off the locator. He stated R#1 was upset with the RP because of the long hospital stay and then transfer to the skilled nursing facility (SNF). He stated R#1 had planned to stay at hotel for one to two (1-2) days, then go to the RP's house. He stated R#1's RP wanted to take R#1 to the hospital for evaluation but the resident declined emphatically. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview with R#1's RP on 9/21/2021 at 4:50 p.m., she stated they all [the family] got Covid-19 in July 2021 from attending a family member's wedding. She stated R#1 became progressively ill and remained in the hospital for two months. She stated the hospital practically insisted on sending her R#1 to rehabilitation unit so she was transferred to the facility on [DATE]. The RP revealed that she was skeptical because there were only three online reviews. She stated R#1 tested negative for Covid-19 twice before the transfer but the facility's admission protocol for unvaccinated admissions was a 14-day quarantine in the Observation Unit on the 200 Hall/Transitional Care Unit (TCU). The RP revealed having a video-chatted with the resident on Monday, Tuesday, and Wednesday but on Thursday, R#1 said she was miserable. The RP revealed that she spoke with the Unit Manager who contacted the doctor who said R#1 could discharge on Monday, 9/20/2021 when oxygen (O2) could be setup at home. The RP revealed that she called the resident several times on Saturday morning, 9/18/2021 but got no answer. The RP revealed that she and another family member decided to go to the facility to check on R#1 and arrived at 10:30 a.m. The RP revealed that she asked about the resident to a lady left the front desk and returned with Licensed Practical Nurse (LPN) AA who informed them that R#1's belongings were gone, and she was missing from the facility. She stated she called 9-1-1 and, when the police arrived, they asked staff to stop searching so they could employ the canine unit to continue the search. The RP revealed that R#1's clothes and handbag were strewn on the side of the road and hanging on trees near the facility. She stated she was allowed to view the facility's surveillance video where she saw R#1 walking around outside the Observation Unit passing one (1) male seated at the nurses' station in the middle of the unit at 3:00 a.m. She stated R#1 was seen again at 3:30 a.m. leaving her room with her baggage. The RP revealed that the resident was seen again outside the facility at 3:38 a.m. walking down the driveway away from the facility with her baggage. The RP revealed that between 5:30-6:00 p.m., the police asked her to access R#1's bank account where she noted four (4) transactions: two at 7:00 a.m. and two at 1:30 p.m. The RP revealed that R#1 later told her she stood in front of the grocery store, 0.6 miles away from the facility, for four hours until they opened. The resident further revealed to the RP that she tapped on a stranger's window and asked a man to take her to a hotel at approximately 9:00 a.m. The resident further revealed to the RP that the stranger paid for the hotel room and called the police. She was not sure why R#1 would have left that hotel and paid for another, but the resident was diagnosed with mild dementia. The RP was grateful that the resident was located safe and sound. Timeline of Elopement per the Administrator and Local Detective: 9/17/21 at 06:30 p.m.: R#1 had video chat with the RP. 9/17/21 at 07:33 p.m.: CNA DD arrived to work (7P-7A) 9/17/21 at 09:32 p.m.: CNA DD last documented ADL care for R#1 9/18/21 at 12:00 a.m.: CNA DD stated she saw R#1 in her room in bed 9/18/21 at 12:33 a.m.: RN CC arrived to work (7P-7A) 9/18/21 at 03:30 a.m.: Surveillance video captured R#1 leaving her room with her baggage 9/18/21 at 03:38 a.m.: Surveillance video captured R#1 outside the facility walking down the driveway away from the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	9/18/21 at 06:00 a.m.: RN CC left morning meds at bedside but did not see R#1. 9/18/21 at 07:30 a.m.: CNA BB left breakfast tray but did not see R#1; time approximate. 9/18/21 at 08:38 a.m.: LPN AA arrived to work (7A-7P) 9/18/21 at 09:00 a.m.: LPN AA did not see R#1 in her room; began to think R#1 was actually missing; time approximate. 9/18/21 at 10:30 a.m.: R#1's RP and another family member arrived at the facility where LPN AA informed them that R#1 was missing from the facility. 9/18/21 at 11:07 a.m.: Local Police arrive at the facility and continue to search for R#1. 9/18/21 at 11:15 a.m.: Administrator notified of the elopement by the Manager on Duty 9/18/21 at 12:15 p.m.: Administrator arrived at the facility and reviewed surveillance video with police officers. 9/18/21 at 01:38 p.m.: Police identify bank card purchase at a drug store approximately four (4) miles away from the facility. 9/18/21 at 03:00 p.m.: Police locate R#1 at a local hotel between 2:30 p.m.-3:00 p.m. near the drug store. R#1 returned home with her RP and declined medical attention. Review of the Daily Schedule for 9/17/21 revealed that two nurses were assigned to the Transitional Care Unit (TCU) where the R#1 was located for the 7:00 p.m. to 7:00 a.m. shift, LPN EE and Registered Nurse (RN) CC. Review of the timecard punch details for 9/17/21 and 9/18/21 revealed that RN CC clocked in at 0.33 (12:33 a.m.) on 9/18/21 and clocked out on 9/18/21 at 6:58 a.m. LPN AA clocked in on 9/18/21 at 8:38 a.m. and clocked out at 20:13 (8:13 p.m.). Review of the Medication Administration Record (MAR) for R#1 revealed she was scheduled for Ondansetron 8 milligrams (mg) and Pantoprazole 40 mg at 6:00 a.m. both were signed as given by RN CC although per the police report and surveillance cameras the resident had eloped from the facility at 3:30 a.m. Review of the facility staff investigation statements revealed that RN CC on 9/18/21 during 6:00 a.m. med pass, she thought the resident was in the bathroom and it was not unusual for the resident to be out of bed since she was independent for ambulation. Unfortunately, I made a mistake and did not physically lay eyes on her during my morning rounds. Further review revealed that CNA DD's written statement revealed that she checked on the resident on 9/18/21 at 12:00 a.m., 4:00 a.m., and 7:00 a.m. and that was the last time she saw the resident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview with RN CC on 9/23/21 at 11:50 a.m. revealed she worked at the facility on Saturday, 9/18/21, from 12:00 a.m. to 7:00 a.m. She confirmed that she was scheduled to work from 7:00 p.m. to 7:00 a.m. on Friday 9/17/21 and Saturday 9/18/21 but she called out on Friday 9/17/21 and reported late (12:33 a.m.) to work on Saturday 9/18/21. RN CC revealed that when she arrived to work on 9/18/21, that LPN EE was the only nurse on the floor, and was working alone. She stated she could see LPN EE was behind in passing medications to the residents therefore she began passing medications (med pass) as soon as she arrived. RN CC stated she started with room [ROOM NUMBER] and passed meds to only a few residents but could not remember them all. She stated one of the rooms she entered to pass medications was R#1's room although the resident was not present at this time during the med pass. She further revealed that after passing medications she sat down at the nurses' station and began charting (update residents medical records with current activity performed by the nurse who enters documentation). RN CC revealed that she did not go back into R#1's room until 6:00 a.m. to administer her medication. She further revealed that she did not see R#1 in her bed or in her room. RN CC revealed that R#1's bathroom light was on, the door was slightly open, and she thought she heard water running therefore, she thought R#1 was in the bathroom. RN CC stated because she thought R#1 was in her bathroom she put her medication cup on her breakfast tray that was sitting on her table tray untouched. She continued to state after placing R#1's medication cup down on the breakfast tray, unattended, she continued with the medication pass on the unit. RN CC further stated it was normal and routine for her to leave R#1's medication for her to take on her own and she does not stay to witness R#1 taking her medication because she is very independent. RN CC revealed that LPN EE administered medication, and that she charted giving the medications, although she wasn't in the facility. RN CC continued to confirm she could not verify when the vitals were actually taken although she documented she was present and had taken R#1's vital information. RN CC further stated that at the end of her shift on Saturday 9/18/21that LPN EE helped her count the narcotic drawer. She continued to state that when she clocked out for the day she did not wait for the on-coming nurse, LPN AA. RN CC stated she started to receive phone calls from the DHS, LPN EE, and CNA JJ regarding R#1. She revealed receiving phone calls asking when the last time she saw R#1 and if she actually saw the resident when she administered medication pass which she reported the last time she saw R#1 was at midnight. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with the Administrator on 9/22/21 at 5:23 p.m. revealed she received a call on 9/18/21 at approximately 11:15 a.m. from Guest Services Manager (GSM), to advise a Code Pink (missing/eloped resident) has been called at the facility. She stated she began to question GSM as to the resident's name and room number, then gave instructions to search the entire facility twice, if resident is not found to expand the search to the outside grounds around the building, and if resident was not found outside to call 911 immediately. She further revealed that after phone call with GSM she checked her facility computer at home and then contacted the police department were the resident lived and ask for a welfare check after explaining the situation. The Administrator revealed that the local police department had responded to the facility, and she was advised that detectives will be taking over the investigation and will be onsite shortly. The Administrator stated she arrived at the facility at approximately noon on 9/18/21. When the Administrator arrived at the facility the family of R#1's was already present, talking with police officers and engaged in the search for R#1. The Administrator further revealed that she shared facility camera footage of the early morning hours with R#1's family which indicates R#1 was outside walking on the side of the building through the alley at 3:38 a.m. on 9/18/21. Review of the surveillance camera video revealed that the resident exited her room, walked down the hallway and entered room [ROOM NUMBER], which at the time was empty, and dislodged the base of the window in order to push the window open and remove the screen so she could climb out of the window with her personal belongings and leave the facility. The Administrator revealed that the Corporate Nurse Consultant (NC) arrived at the facility on 9/18/21, cannot recall time, and a head count of remaining residents on TSU and instructed maintenance to check all doors and windows for security. The Administrator revealed that phone calls were being made to the area hospitals for any recent admissions that fit R#1s description although no one fit the description. The Administrator revealed that R#1's purse and clothing were found in the trees and bushes just outside the facility property, but R#1's wallet and cell phone were missing among her personal items. The Administrator further stated the family and facility tried continuously to reach R#1 by phone until approximately 4:30 p.m. when it was determined the phone was turned off. The Administrator revealed that the Detectives advised the family to check the resident's bank records to determine if the resident had used her credit card. The family was able to gain access to R#1's bank account and was able to determine that R#1's credit card had been used at a drug store and a local hotel. The Detective contacted her stating the resident had been located and is safe and with her family. The Administrator further revealed that the investigation determined that CNA DD was the last person to see the resident and that RN CC charted giving medications to R#1 but did not and did not attempt to locate the resident. The Administrator revealed that RN CC should have waiting for LPN AA to give report and that the Administrator was not aware that RN CC had been 5.5 hours late for her shift. Observation of room [ROOM NUMBER] on 9/23/2021 at 5:35 p.m. revealed the window was repaired with the two (2) screws added at the top of the vertical window and the stud/stop at the base of the window. There was a bush outside the window, approximately 4-feet high, which R#1 could have fallen into while climbing out of the window. The ground was covered in pine straw. Observation on 9/23/21 at 5:48 p.m. of the outside grounds on revealed a wooded area to the right of the driveway (moving away from the facility) which had a drop-off into which R#1 could have fallen if she lost her balance and/or became hypoxic without her oxygen. An interview with the Maintenance Director (MD) on 9/22/2021 at 10:00 a.m., revealed they discovered the window in room [ROOM NUMBER] and it appeared R#1 lifted the window from the base of the window seal, removed the screen and climbed out since the room was on the ground level. The MD stated he found the window screen on the ground outside the window. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with Licensed Practical Nurse (LPN) AA on 9/22/2021 at 2:50 p.m., she stated she did not work at the facility on Friday, 9/17/2021 but was scheduled for Saturday, 9/18/2021, 7:00 a.m. to 7:00 p.m. (7A-7P) shift, however she was late and did not report to work until 8:33 a.m. LPN AA stated she was supposed to relieve RN CC who worked the 7:00 p.m. to 7:00 a.m. (7P-7A) shift but RN CC had already left and did not leave a report concerning the residents on the 200 Hall. She stated she determined sometime after 9:00 a.m. that R#1 was not in her room, her belongings were gone, and her breakfast tray was on the bedside table untouched along with two pills in a cup which she determined were Zofran (for nausea) and Pantoprazole (for gastroesophageal reflux disease-GERD). She stated she did not touch anything in the room and began to search for R#1 around the facility. She stated she was called to the front desk about 10:30 a.m. where R#1's RP and another family member were waiting to see R#1 and she informed them R#1 was missing from the facility. She stated she informed the Manager on Duty who was the Guest Services Manager (GSM) and she called the Administrator and the Director of Health Services (DHS). She stated the Administrator instructed her to call the local police and get the staff to help continue the search for R#1. An interview with Certified Nursing Assistant (CNA) BB on 9/22/21 at 2:30 p.m. revealed [NAME] she worked the 7:00 p.m.-7:00 a.m. shift on Friday, 9/17/2021. She stated she first saw R#1 in her room on 9/17/2021 at approximately 7:15 p.m. during shift change when she was counting all residents present on the 200 Hall/TCU. She revealed not seeing the resident again during her shift. She further revealed staying late after her shift on Saturday morning (9/18/21) to help out and passed out the breakfast trays when they came to the unit. She stated R#1 was not in her room and assumed she was nearby because she was able to self-ambulate, so she left the tray on her bedside table. An interview with LPN FF on 9/22/21 at 3:20 p.m. revealed she worked at the facility on Saturday 9/18/21, on the 7:00 a.m.-7:00 p.m. shift. She further revealed receiving the shift report from LPN EE although RN CC had already left for the day but left a written report which was uneventful. She stated she was familiar with R#1 but had little interaction with her. She stated when she did have the opportunity to speak to R#1, she never expressed wanting to go home or plans to go home. She stated R#1 was always pleasant, could make her needs known, and ambulated and toileted independently. An interview with the DHS on 9/22/2021 at 5:52 p.m. revealed that she did not work at the facility on Friday 9/17/2021 but was called to come in because of the Code Pink related to R#1 who was admitted on [DATE]. The DHS revealed that she expected all nursing staff to clock in on time, stay on duty until their relief arrives, call her if they expect to be late to work, call her two hours in advance if they can't come to woke, provide a complete shift report with walking rounds, and nurse should conduct a medication count. She stated she was aware the nurses assigned to R#1 did not meet her expectations from 9/17/2021 through 9/18/2021 as evidenced by leaving medications at the bedside then charting as giving the medications, and neither the RN nor the CNA had looked for the resident when she was in her room. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with LPN EE on 9/22/2021 at 7:05 p.m. revealed that he worked Friday, 9/17/2021, on the 7:00 p.m. to 7:00 a.m. shift and was working with CNA DD and CNA JJ. He revealed that R#1 was pleasant, quiet, didn't need much help, would take her medications, and had a cordial relationship with her roommate and did not express to him a desire to go home. He stated he heard later that R#1 wanted to go home but couldn't go home on Friday, 9/17/2021 because they couldn't set up her oxygen (O2) at home until Monday, 9/20/2021. He stated he last saw R#1 at 10:00 p.m. peeking out of the room into the hallway. He stated he did not recall seeing her anymore after that time. He revealed not hearing or seeing anything out of the ordinary that shift, particularly between the hours of 3:00 a.m. - 4:00 a.m. He stated, when he's not attending to residents directly, he mostly sits at the nurses' station to chart. He further revealed that if disoriented residents or those with nighttime confusion were wondering, he would try to redirect them and get them back to their rooms. He stated, if resident's gait is steady and they're cognitive, staff let them do their own thing as much as possible. He stated if a resident was up and about in the middle of the night, he would ask about their needs and engage with resident and redirect them back to their room. He stated the normal protocol for med pass, if the resident is not available, is to check the bathroom and try to locate the resident. He stated he would hold the meds and return them to the medication cart if the resident was unavailable. A telephone interview with CNA JJ on 9/23/21 at 9:35 a.m. revealed she did not work at the facility on Friday 9/17/21 but she did work at the facility on Saturday 9/18/21 from 7:00 a.m. to 3:00 p.m. CNA JJ stated after reporting to work Saturday morning she began to pass breakfast trays at approximately 7:15 a.m. and that CNA BB was responsible for passing breakfast trays for her residents that included R#1. CNA JJ further revealed that LPN AA reported to work late on 9/18/21 and reported to the at approximately 9:45 a.m. At approximately 10:00 a.m. she overheard LPN AA talking with LPN FF telling her that the family for R#1 was at the front desk and want to see her, but she is not in her room. CNA JJ revealed that staff began to look for the resident at that time. CNA JJ revealed that she went to R#1's room and noticed her breakfast tray on her tray table had been untouched. CNA JJ stated she asked CNA BB if she saw R#1 when she brought her breakfast tray to her room and CNA BB replied, no. A telephone interview with LPN KK, Unit Supervisor, on 9/23/21 at 9:45 a.m. revealed she was at the facility on Friday 9/17/21 and worked from 7:00 a.m. to 7:00 p.m. although she did not work on 9/18/21. LPN KK revealed being familiar with R#1 and that the resident did not like to be in isolation, was very alert, and cooperative in taking medication. She continued to state during her interactions with R#1 she never displayed signs and never voiced wanting to leave the facility. LPN KK stated she encountered R#1 twice during her shift on Friday, the first time the resident came to the Nurses' Station at approximately 3:00 p.m. without her oxygen on. LPN KK redirected the resident to her room and explained she could not be out of her room due to isolation status. She further revealed she last saw R#1 on Friday at approximately 4:30 p.m. during medication pass and she witnessed R#1 take her medication at that time. A telephone interview with CNA DD on 9/23/21 at 12:36 p.m. revealed that she worked at the facility on Friday 9/17/21 from 7:00 p.m. to 7:00 a.m. although she arrived late, 7:33 p.m., for her shift and was assigned to R#1. CNA DD further revealed that R#1 was independent and could ambulate independently. She revealed that she did see resident in her room during her rounds on Friday 9/ [TRUNCATED]