STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415084	A. Building B. Wing	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elmhurst Rehabilitation & Healthcare Center	50 Maude Street Providence, RI 02908

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 36961 Based on record review, surveyor observation, staff, and resident representative interview, it has been determined that the facility failed to develop and implement a baseline care plan that includes the instructions needed to provide effective and person-centered care for 1 of 5 residents reviewed for elopement risk, Resident ID #1. Findings are as follows: Record review revealed the resident was admitted to the facility in October of 2021 from an acute care hospital. Further review revealed a document titled, Referral Information which states in part, Referral Comments .Patient ready for discharge needs secured dementia unit ELOPEMENT RISK . Review of the progress notes revealed a note dated 10/18/2021 written by the Director of Rehabilitation Services which states in part: [representative] reports primary barrier to dc [discharge] has been paranoid delusions in which [s/he] wanders away from home .has had recent stays at [psychiatric hospital] trialed [assisted living facility] (tried to break window with chair) . During an interview with the resident's representative on 10/26/2021 at 12:15 PM she revealed the resident has made prior elopement attempts at their private residence and at a previous community assisted living residence. She stated she communicated this to the facility staff at a planning meeting conducted at the facility on 10/18/2021. Review of a baseline care plan initiated on 10/15/2021, failed to reveal evidence of a care plan related to the resident's prior elopement attempts. Review of an initial elopement assessment conducted by the facility dated 10/15/2021 revealed the resident did not have a history of eloping and was not at risk for elopement. Review of a community reported complaint submitted to the state agency, dated 10/25/2021, revealed the resident had eloped on 10/23/2021 and was brought back to the facility by the police. During an interview with the Minimum Data Set Assessment Coordinator on 10/26/2021 at 3:00 PM, she stated she reviews all the paperwork and interviews the resident and/or the representative to obtain information to formulate a baseline care plan. She was unable to explain why there was no care plan for elopement behaviors for the resident who has had a history of prior elopement attempts.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36961 Based on surveyor observation, staff interview, and record review it has been determined that the facility failed to provide an ongoing program on the dementia unit to support residents in their choice of activities designed to meet the interests and support the well-being of each resident, based on the comprehensive assessment, care plan, and preferences of each resident for 3 of 3 residents reviewed for activities, Resident ID #'s 1, 4 and 5. Findings are as follows: 1. Record review for Resident ID #1 revealed the resident was admitted to the facility in October of 2021 with diagnoses that include but are not limited to Alzheimer's disease, delirium, dementia with behavioral disturbance and cognitive communication deficit. Review of a care plan dated 10/15/2021, revealed that the resident has impaired cognitive function with interventions including to engage in simple, structured activities and further stated, I prefer (specify the activities). There were no activities specified in the care plan. Further review revealed an additional care plan dated 10/23/2021 which revealed the resident is an elopement risk/wanderer with interventions including, Distract me from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. I prefer [no activities specified] .Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory box. Review of a progress note dated 10/18/2021 revealed the following: [spouse] reports she has met with activities dept [department] and that [resident] enjoys music, singing, dancing. Surveyor observations on 10/26/2021 at 8:45 AM and 10:30 AM, 10/27/2021 at 10:15 AM and 10/28/2021 at 9:15 AM revealed the resident was wandering on the dementia unit with no attempts made by staff to provide diversional activities. During an interview on 10/27/2021 with the activities aid, Staff B, she was unable to explain what activity interventions were specified for the resident. During a surveyor interview with the Activities Director on 10/28/2021 at 11:20 AM, he indicated that he was working on an activity plan for the dementia unit, but it was still in progress. He stated he had only himself and one activity aid for the entire facility. He was unaware that the resident was not provided with diversional activities to prevent wandering. 2. Record review for Resident ID # 4 revealed the resident was admitted to the facility in January 2015 with diagnoses which include, but are not limited to, dementia, legal blindness, Alzheimer's disease, and history of falling. (continued on next page)

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review revealed an annual Minimum Data Set (MDS) assessment dated [DATE] which indicated the resident is severely cognitively impaired. Further review of the MDS assessment indicated the resident's activity preferences were provided by the resident representative. The assessment further indicated it was very important for the resident to listen to music s/he likes and participate in activities with groups of people. Review of a care plan dated 12/27/2016 revealed the resident is at risk for falls with interventions including to keep in preferred activities as much as possible and provide diversional activities to reduce the risk of getting up unattended. Additionally, a care plan dated 6/2/2020 which revealed the resident is dependent on staff for activities and likes to have nails done and listen to music. Interventions include assist and escort to activity functions and prefer to sit in common areas to be around staff. Surveyor observation revealed the following: -On 10/26/2021 from 9:45 AM to 10:15 AM, the resident was observed sitting in a reclining geriatric chair in the hallway. The chair was positioned next to the wall. The resident appeared to be attempting to get out of the chair with both legs dangling on the left side of the footrest. Staff were observed at the nurse's station adjacent to the resident. Staff failed to provide diversional activities to reduce the risk of the resident getting up unattended. -On 10/26/2021 at approximately 1:00 PM and 10/27/2021 at 9:50 AM the resident was observed sitting in a reclining geriatric chair in the hallway next to the wall. No staff were observed interacting with the resident at the above-mentioned times. During an interview on 10/27/2021 at 11:20 AM with the activities aid, Staff B, she stated she was unaware of the resident's activity preferences and stated the resident usually sits in the hallway and she gives the resident something to hold as an activity. During a surveyor interview with the Activities Director on 10/28/2021 at 11:20 AM, he indicated that he was working on an activity plan for the dementia unit, but it was still in progress. He was unaware of the resident's activity preferences. 3. Record review revealed Resident ID #5 was admitted to the facility in June of 2021 with diagnoses that include but are not limited to dementia with behavioral disturbance, Alzheimer's disease and attention and concentration deficit. Record review of an annual MDS assessment dated [DATE] revealed the resident is severely cognitively impaired. The assessment further revealed it is very important for the resident to listen to music, go outside and get fresh air when the weather is good and do things with groups of people. Further record review failed to reveal evidence of a care plan for activities or evidence of the resident's participation in any of his/her preferred activities. Surveyor observations on 10/26/2021 at 9:00 AM and 10/27/2021 at 10:15 AM revealed the resident in the common area sitting at a table with a newspaper in front of him/her on the table. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/27/2021 at the time of the above observation, with nursing assistant, Staff C, she stated the resident does not like to participate in activities and likes to sit in the common area. During a surveyor interview with the Activities Director on 10/28/2021 at 11:20 AM, he was unable to explain why the resident did not have a current care plan for activities and could not provide evidence that the resident had participated in his/her preferred activities.

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37158 Based on record review and staff interview it has been determined that the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, that meet each resident's physical, mental, and psychosocial needs for 1 of 1 resident reviewed for abnormal laboratory values and 1 of 1 resident reviewed for non-pressure related wound care, Resident ID #'s 2 and 9. Findings are as follows: 1. Record review for Resident ID #2 revealed s/he was admitted to the facility in August of 2021 with medical diagnoses including, but not limited to, diabetes mellitus, hyperlipidemia, acquired absence of right leg above the knee and left leg below the knee, chronic kidney disease, and cerebrovascular disease. Record review of the resident's liver function test (LFTs-blood tests used to help diagnose and monitor liver disease or damage) dated 9/20/2021, revealed the following baseline LFT laboratory values: -Alkaline Phosphatase (ALK) 95 normal range (42-121 U/L (units per liter) -Aspartate Aminotransferase (AST) 9 normal range (10-42 U/L) -Alanine Transaminase (ALT) 4 normal range (10-60 U/L) Further record review of the resident's subsequent LFTs obtained on the dates listed below revealed the following values which indicated that the LFT levels were progressively increasing: 10/4/2021 ALK 101 AST 13 ALT 9 10/11/2021 ALK 128 AST 65 ALT 54 10/14/2021 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	ALK 168 AST 176 ALT 143 10/18/2021 ALK 219 AST 351 ALT 224 Record review of the resident's order summary revealed the following current physician orders with a start date of 8/24/2021: - Rosuvastatin (a medication that can cause an increase in liver enzyme levels) 20 milligrams (mg) by mouth at bedtime for hyperlipidemia - Acetaminophen (a medication which is metabolized in the liver) 975 mg by mouth every 8 hours for pain/discomfort Record review of the October 2021 Medication Administration Record (MAR) revealed both Rosuvastatin and Acetaminophen continued to be administered, despite the increasingly elevated LFT levels, until the resident was discharged to an acute care hospital on 10/20/2021. Record review of a progress note dated 10/4/2021 at 3:07 PM, authored by the Nurse Practitioner (NP), Staff D, revealed he examined the resident's status, reviewed medications, and labs. Additionally, he indicated the resident was on Rosuvastatin for hyperlipidemia and stated, will monitor lfts . Record review of a progress note dated 10/11/2021 at 3:09 PM, authored by Staff D, revealed he examined the resident's status and reviewed his/her medications. Additionally, he indicated that lab values were also reviewed that day, and that the resident was on Rosuvastatin for hyperlipidemia and stated, will monitor lfts . Record review of a progress note dated 10/18/2021 at 4:05 PM, authored by Staff D, he revealed he examined the resident's status, reviewed the resident's medications and labs. Additionally, he indicated the resident was on Rosuvastatin for hyperlipidemia and stated, will monitor lfts . Further record review failed to reveal that any new orders for interventions were implemented to address the increasingly elevated LFT levels. Additionally, review of the resident's physician orders revealed an order for weekly CBC with differential (complete blood count-blood test to help diagnose and monitor different conditions) and CMP (Comprehensive Metabolic Panel-blood test used to evaluate liver function, kidney function, and nutrient levels) every Monday. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Further review of the resident's laboratory report results dated 9/27/2021 revealed handwritten documentation at the bottom of the report which read, Repeat BMP [Basic Metabolic Panel-laboratory test that provides information on body's metabolism including kidney function and the balance of electrolytes] 9/30. Record review failed to reveal evidence that these laboratory results were ordered and/or obtained on 9/30/2021. Subsequent record review of the resident's laboratory report results from 10/14/2021 revealed handwritten documentation at the bottom of the report, which read, [check mark] CBC, CMP tomorrow. Record review failed to reveal evidence that these laboratory results were ordered and/or obtained on 10/15/2021. During an interview with the Director of Nursing Services on 10/29/2021 at approximately 4:40 PM, she was unable to provide evidence that the laboratory tests for 9/30/2021 and 10/15/2021 were obtained. Record review of a nursing progress note dated 10/20/2021 revealed the resident's BMP values, which were ordered and obtained that day, were reviewed by the physician. The note further revealed that based on the elevated creatinine levels, the physician ordered for the resident to be further evaluated at the hospital. Record review of the hospital continuity of care documentation dated 10/20/2021, revealed the resident's admitting diagnoses included, but were not limited to, acute liver failure, liver derangements (elevated INR, high LFTs), acute encephalopathy, and acute kidney injury. The LFT values were obtained at the hospital on 10/20/2021 and revealed the following: ALK 321 AST 464 ALT 277 During a surveyor interview on 10/28/2021 at 1:30 PM with Staff D, he revealed when he assesses a patient, he reviews the entire medication profile. Further stating that he was not aware the resident was on standing Acetaminophen, and he would have held this medication with the elevated LFT levels. Additionally, during a subsequent interview on 10/29/2021 at 2:07 PM with Staff D, he revealed that after reviewing the LFT values on 10/18/2021, he intended to give an order to hold the Rosuvastatin but failed to do so. During a surveyor interview with the resident's physician on 10/29/2021 at 1:52 PM, during which the LFT values were reviewed with him. The physician revealed that he was unaware of the resident's elevated LFT values over the last month and if he was aware, he would have discontinued both the Acetaminophen and Rosuvastatin medications. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	2. Record review revealed Resident ID #9 was admitted to the facility in July of 2021 with medical diagnoses including, but not limited to, cellulitis of the right great toe, peripheral vascular disease, and diabetes mellitus. Record review of the resident's Minimum Data Set (MDS) admission assessment dated [DATE] revealed the resident was coded as having a surgical wound upon admission. Record review revealed the resident is seen routinely by an outside podiatrist for management to his/her right foot surgical wound. Record review of the podiatry consults revealed a consult recommendation dated 9/2/2021 which states in part, .Iodosorb [an antimicrobial gel which includes iodine], 2x2 gauze to proximal wound . Record review of the podiatry consults revealed a consult recommendation dated 9/10/2021 which states in part, .leave dressing intact R [right] foot; only change if strike through noted . Record review of the September and October 2021 Treatment Administration Record revealed a treatment order to the right foot wound dated 7/28/2021 to apply Betadine followed by dry protective dressing and wrap with kling. Further review of the TAR failed to reveal evidence that an order for Iodosorb was implemented on 9/2/2021. Additionally, the Betadine treatment order continued to be signed off as completed on 9/11, 9/12, 9/13, 9/14, and 9/15, despite having a recommendation on 9/10/2021 to leave the dressing intact. Lastly, the Betadine order was discontinued on 9/17/2021 and the record failed to reveal a treatment order to change the dressing to the right foot wound, as needed, if strike through noted, per the podiatrist recommendations on 9/10/2021. During a surveyor interview on 10/29/2021 at 3:05 PM with the Wound Nurse, she acknowledged that the recommendation for Iodosorb was not implemented per the podiatrist recommendations. Additionally, she was unable to provide evidence that a treatment order was implemented, as needed, in the event of a strike through to the right foot dressing.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36961 37158 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to provide necessary treatment and services, consistent with professional standards of practice, to promote wound healing and prevent new ulcers from developing for 3 of 5 residents reviewed who have actual pressure ulcers, Resident ID #'s 2, 10 and 11. Findings are as follows: 1. Record review for Resident ID #2 revealed s/he was admitted to the facility in August of 2021 with diagnoses including, but not limited to, diabetes mellitus, acquired absence of right leg above the knee, and acquired absence of left leg below the knee. Review of the resident's Minimum Data Set (MDS) admission assessment dated [DATE] revealed the resident is coded as being at risk for pressure ulcers. Record review of the assessment titled; Weekly Skin Check dated 9/14/2021 revealed a new unstageable (wound bed covered in slough) pressure ulcer to the resident's coccyx. Further review of the document failed to reveal any further description or measurements of the new pressure ulcer. Record review of the September 2021 Treatment Administration Record (TAR) failed to reveal evidence that a treatment for the resident's pressure ulcer was implemented until 9/20/2021, which was 6 days after the ulcer was first identified. During a surveyor interview on 10/28/2021 at 12:58 PM with the Unit Manager, Staff E, she acknowledged she was the nurse who identified the resident's unstageable pressure ulcer to his/her coccyx on 9/14/2021. Additionally, she was unable to provide evidence that a treatment order was implemented prior to 9/20/2021. During an interview with the Wound Nurse on 10/28/2021 at 1:47 PM, she acknowledged being made aware of the unstageable pressure ulcer on 9/14/2021. She could not provide evidence that measurements or a description of the wound were obtained. Additionally, she revealed she reported the pressure ulcer to the provider on 9/14/2021 but failed to implement the treatment that was ordered for the wound. 2. Resident ID #10 was admitted to the facility in May of 2020 with diagnoses including, but are not limited to, Parkinson's disease and a pressure ulcer of the right hip, stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle). Record review of a quarterly MDS assessment dated [DATE] revealed the resident is cognitively intact, has a stage 4 pressure ulcer and is at risk for further skin injuries. Review of the physician's orders revealed an order dated 9/17/2021 with a discontinuation date of 10/28/2021, which indicated to perform wound care twice daily. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a care plan initiated on 5/6/2020 revealed the resident has an actual pressure ulcer and is at risk for further pressure ulcer development. Further review revealed an intervention initiated on 5/6/2020 which stated assess/record/monitor wound healing with dressing changes and during weekly skin rounds . Further review of the progress notes failed to reveal evidence the wound was monitored for wound healing at each dressing change. Additional review of physician's orders revealed an order dated 5/12/2020 which reads bilateral heel boots on at all times while in bed, may remove for care. During a surveyor observation on 10/29/2021 at 1:15 PM revealed the resident was seen with his/her heels resting flat on the bed, without heel boots. During an interview with the resident at the time of the observation, s/he stated s/he used to wear heel boots but has not in quite some time. Further observation of the resident's room failed to reveal the resident's heel boots. During an interview with Nurse, Staff F, immediately following the observation, she observed the resident's room for the heel boots and was unable to locate the boots. She stated she was unsure where the heel boots were located and would have to obtain new boots for the resident. During an interview on 10/29/2021 at 3:00 PM, with the Wound Nurse, she revealed she would expect a progress note to be written with each dressing change and could not provide evidence the resident's wound was monitored for healing at each dressing change. 3. Record review revealed that Resident ID #11 was admitted to the facility in June of 2021 with diagnoses including, but not limited to, hemiplegia (paralysis in one side of the body) and hemiparesis (weakness or inability to move one side of the body), type 2 diabetes mellitus, and pressure ulcer of sacral region [area located at the bottom of the spine], stage 4. Record review revealed a care plan initiated on 5/12/2021 which states in part, I have sacral pressure ulcer and/or potential for pressure ulcer development r/t [related to] impaired mobility. with interventions including, . Administer treatments as ordered and monitor for effectiveness .Monitor dressing during care to ensure it is intact and adhering . Review of the October 2021 TAR revealed a physician's order dated 7/29/2021 with a discontinuation date of 10/11/2021 which states, Change wound Vac three times a week, Wash with Normal Saline, pack with foam drape and set negative pressure to 125mmHg [millimeters of mercury] one time a day every [Tuesday, Thursday, Saturday] . During a surveyor interview with the resident on 11/2/2021 at 10:30 AM s/he revealed that staff, sometimes do the wound care and sometimes they don't. Additional record review revealed the Wound Nurse Practitioner had assessed and debrided the resident's wound on 10/14/2021. Further review revealed she had made recommendations to clean the wound with normal saline, apply Iodosorb and cover with DCD (dry clean dressing) to change daily and PRN (as needed), which was not implemented until 10/19/2021. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further record review revealed, a physician's order dated 10/19/2021 which states, COCCYX WOUND: wash with NS [normal saline], pat dry. Apply iodosorb to wound bed f/b [followed by] DPD [dry protective dressing] daily and PRN everyday shift for wound care . indicating that the facility failed to implement a treatment order until 10/19/2021, which was 4 days after the recommendation was made. During a surveyor interview on 11/2/2021 at 10:47 AM with the Wound Nurse, she was unable to provide evidence that a treatment order was in place and that wound care was completed from 10/11/2021 through 10/13/2021 and again from 10/15/2021 through 10/18/2021. During a surveyor phone interview with the Wound Nurse Practitioner on 11/3/2021 at 12:03 PM she indicated that she would expect wound care to be completed daily. 43987

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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** 36961 Based on record review, surveyor observation, staff and resident representative interview, it has been determined the facility failed to provide adequate supervision and assistance devices to prevent accidents for 5 of 6 residents reviewed for elopement behaviors, Resident ID #'s 1, 6, 7, 8 and 10. Findings are as follows: Review of the facility policy titled, Wandering and Elopements states in part, Policy heading .The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Policy Interpretation and Implementation . 1. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. 2. If an employee observes a resident leaving the premises, he/she should: a. attempt to prevent the resident from leaving in a courteous manner; b. get help from other staff members in the immediate vicinity, if necessary; and c. instruct another staff member to inform the charge nurse or director of nursing services that a resident is attempting to leave or has left the premises . 4. When the resident returns to the facility, the director of nursing services or charge nurse shall: . e. complete and file an incident report; and f. document relevant information in the resident's medical record. 1. Review of a community reported complaint submitted to the state agency, dated 10/25/2021, revealed Resident ID# 1 who was residing on the locked dementia unit had eloped on 10/23/2021 and was brought back to the facility by the police. Record review for Resident ID #1 revealed the resident was admitted to the facility in October of 2021 with diagnoses including, but are not limited to, Alzheimer's disease, delirium, and dementia with behavioral disturbance. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further record review revealed a document dated 10/15/2021 from the resident's most recent acute care hospital visit titled, Referral Information which stated in part, Referral Comments .Patient ready for discharge needs secured dementia unit ELOPEMENT RISK . Review of the resident's progress notes revealed a note dated 10/18/2021 written by the Director of Rehabilitation Services which states in part, [representative] reports primary barrier to dc [discharge] has been paranoid delusions in which [s/he] wanders away from home .has had recent stays at [psychiatric hospital] trialed [assisted living facility] (tried to break window with chair) . During an interview on 10/26/2021 at 10:30 AM with the resident representative, she revealed the resident has made prior elopement attempts at their private residence and at a previous community assisted living residence. She stated she communicated this to the facility staff at a planning meeting conducted at the facility on 10/18/2021. Review of an initial elopement assessment dated [DATE] revealed the resident did not have a history of eloping and was not at risk for elopement. Review of a baseline care plan initiated on 10/15/2021, failed to reveal evidence of a care plan related to the resident's prior elopement attempts. Review of a Quality Assurance Performance Improvement Plan dated 10/25/2021 revealed the following: Resident was observed leaving facility with a family member, returned to facility 20 minutes later by police. During an interview with the Director of Nursing Services (DNS) on 10/26/2021 at 10:35 AM, she revealed the resident eloped from the facility with a visitor after following her on to the elevator in the secured dementia unit. She further stated a staff member, Staff G, was present in the parking lot and witnessed the resident leave the facility with whom Staff G assumed was a family member. She further stated Staff G watched the resident walk to the main road ([NAME] Street), he then left his vehicle to assist the resident when he realized the resident was no longer with the family member. The DNS stated Staff G then witnessed a police car approach the resident. She stated Staff G did not approach the resident and the resident was escorted back into the building by the police officer. She stated she did not report the event to the state agency because the resident did not leave the sight of Staff G the entire time s/he was out of the building. During an interview on 10/26/2021 at 3:35 PM with Staff G, he revealed he had arrived at the facility between 3:00 PM and 4:00 PM to retrieve an item he had left at the facility. He was in the parking lot sitting in his car. He further stated he watched the resident leave the building with a visitor. He then stated he observed the visitor walk to the bus stop on the main road ([NAME] Street) and watched the resident proceed down a side street. He then stated he exited his vehicle to approach the resident but by that time a police officer had arrived and was assisting the resident. He stated he did not continue to approach the resident because he assumed the police would assist the resident back to the building. He then stated he entered the building and called the DNS. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a police incident report dated 10/23/2021 and timed 3:51 PM revealed the city police were called for a wellbeing check by a caller who was standing by with a person saying s/he was lost approximately 0. 3-0.4 miles or approximately 7-9 minutes away from the facility on [NAME] Ave/Pasteur Street. During an interview with the resident representative on 10/26/2021 at 10:30 AM it was revealed that the police officer used a phone that the resident had on him/her that the representative had placed in his/her pocket earlier that day (10/23/2021). The police officer told the representative that they were taking the resident to the representative's residence. The representative then told the officer the resident resided at the facility and not his/her private home. The officer then told the representative they would return the resident back to the facility. During an interview on 10/27/2021 at 12:23 PM with Staff H, he stated at approximately 4:15 PM on 10/23/2021 he was in the rehabilitation room when he was approached by a police officer. The police officer stated they found a resident wandering down the street and that they were returning him/her back to the facility. Staff H met the resident in the lobby with another officer identified him/her as a resident who resided on the dementia unit. Staff H stated the resident had a steady gait, was wearing a beige jacket and a mask under his/her chin. Staff H stated the resident was well appearing. During an interview on 10/27/2021 at 12:30 PM with Staff I, the nurse who was working on the dementia unit when the resident was returned to the unit, she revealed she was unaware the resident had left the facility until s/he was brought back to the unit by Staff H. Staff I was unable to provide an accurate timeline of the events. During an interview on 10/27/2021 at 4:00 PM with the person identified to have called the police to report a lost individual, she revealed she was visiting a friend at the facility on 10/23/2021. Review of a visitor log revealed she entered the facility at 2:15 PM. She could not recall the time she left the facility. She stated she was exiting through the elevator on the dementia unit when an individual followed her on to the elevator. She stated she asked if this individual was a resident and the individual stated no. She stated the individual appeared to be well dressed and s/he had a mask under his/her chin, and she was unsure if s/he was a resident. She further stated she walked to the reception desk after exiting the elevator and approached the receptionist with her concerns. She stated the receptionist then asked the individual if s/he was a resident and s/he stated no. The visitor then left the building and went to sit in her car. She proceeded to watch the individual leave the facility and walk up towards the highly traveled main road. She observed him/her cross a highly traveled main road and continue into the neighborhood. She stated she followed him/her down the street in her vehicle. She then stated she noticed the individual appeared to be lost. She approached him/her and then called the police. The individual was identified as a resident of the facility. An attempt was made to interview the receptionist, but he was not available for interview. The above information of the actual account of events was presented to the facility. They were unable to explain the discrepancy of the events that occurred on 10/23/2021 on the day the resident eloped 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	Additionally, during a surveyor observation on 10/26/2021 at 2:00 PM the resident and the resident's representative were observed entering the elevator on the secure dementia unit. The resident representative entered a code that enabled the elevator door to open and then entered the elevator. The resident was observed with a wander guard (a device worn by a resident that triggers alarms and can lock monitored doors to prevent the resident leaving unattended) on the right ankle. There was an additional wander guard alarm inside the elevator which failed to alarm, it was not triggered by the resident's wander guard as the alarm inside the elevator is intended to, and the resident left the secure unit with the resident representative. During an interview with the DNS immediately following the observations, she stated she was unaware the wander guard alarm system had not been alarming when residents entered the elevator. There were various discrepancies noted in the facility's account of the elopement such as the actual location of where the resident was found and the resident being in sight of staff the entire time. From the parking lot at the facility to the location where the resident was found is 0.3-0.4 miles away and not in eyesight from the parking lot. This facility failed to provide adequate supervision to a cognitively impaired resident resulting in the resident eloping from the facility on 10/24/2021 and crossing a highly traveled road and being brought back by the police. This delay and lack of supervision placed the resident in immediate jeopardy for serious harm, injury, or death due to his/her diagnoses, cognitive impairment, and decreased functional abilities. 2. Record review Resident ID #6 was admitted to the facility in August of 2021 with diagnoses that include, but are not limited to, schizophrenia and infection of the bone of the left foot and ankle. Record review of a wander/elopement risk evaluation dated 8/24/2021 revealed the resident was not at risk for elopement. Review of the progress notes revealed the following: -progress note dated 9/15/2021 at 15:22 which reads After several attempts to get on elevator. Wander guard applied to RLE [right lower extremity] . -progress note dated 9/15/2021 at 22:11 which reads in part, Wander guard in place to ankle. No attempts made to elope off of unit. -progress note dated 9/20/2021 at 21:32 which reads in part, Wander guard in place to lower ext. [extremity]. -progress note dated 9/21/2021 at 15:22 which reads in part, Continues to wander on unit. Right LE [lower extremity] wander guard in place. -progress note dated 9/22/2021 at 16:17 which reads in part, Continues to wander in hallways. Wander guard in place to RLE. -progress note dated 9/23/2021 at 22:38 which reads in part, .Wander guard in place to Right ankle, no attempts made to elope off of unit . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-progress note dated 9/24/2021 at 8:19 which reads in part, Spoke with daughter to provide update and discuss possible discharge as she requested. Daughter asking if [resident name redacted] anxiety and hallucination have resolved; made aware of pacing, occasional refusal of care. Daughter concerned of ability to care for [resident] due to past leaving the home to preach to others in the street. -progress note dated 9/26/2021 at 22:06 which reads in part, .Wander guard in place to RLE . -progress note dated 9/27/2021 at 22:06 which reads in part, .pt [patient] packing up all personal belongings, looking to be d/c [discharged] home Redirected several times with + results. Stood by elevator, verbalized daughter was picking [him/her] up. Wander guard in place to RLE. -progress note dated 9/29/2021 at 22:04 which reads in part, .Elder noted very agitated this afternoon, exit seeking stating [s/he] needed to go home to take care of business and [s/he] needed to get out of [him/her]. Redirection attempted with no success. -progress note dated 10/7/2021 at 16:14 which reads in part, .Resident packed all [his/her] clothes in a suitcase. Patient states My doctor discharged me, and my daughter is here to take me home please open the door for me . -progress note dated 10/11/2021 at 13:53 which reads in part, .Resident increasing behavior, starting crying and states' I want to go home . -progress note dated 10/12/2021 at 8:47 which reads in part, .Resident lay down in front on the nursing station in the floor, and states I am going to be in the floor until I get discharge, I want to go home . Review of a quarterly minimum data set assessment dated [DATE] revealed the resident did not exhibit wandering behaviors. Further record review failed to reveal evidence of a wander/elopement risk assessment following the above noted elopement attempts, consistent monitoring of wander guard function, placement or a care plan initiated for wandering/elopement until 10/24/2021. During an interview on 10/27/2021 at 2:00 PM with the Regional DNS, he was unable to explain why the resident was not accurately assessed for wandering/elopement behaviors and why a risk assessment, monitoring of the wander guard, or a care plan was not completed until 10/24/2021. 3. Resident ID #7 was admitted to the facility in January of 2019 with diagnoses that include, but are not limited to, Alzheimer's disease, dementia with behavioral disturbance, and psychotic disorder with delusions. Record review of the October 2021 electronic treatment administration record (TAR) revealed a treatment order dated 5/1/2020 which read, check placement of Wander Bracelet on every shift. Further review of the TAR revealed on 10/4/2021 day shift, 10/12/2021 evening shift, 10/14/2021 day shift and 10/18/2021 day and evening shift, no evidence the wander bracelet was checked for placement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a surveyor observation on 10/26/2021 at approximately 3:00 PM of Resident ID #7, it was revealed the resident had a wander bracelet on the left ankle. The nurse, Staff J, was asked to enter the code to open the elevator door. The resident then walked into the elevator, in the presence of the surveyor. No alarm was triggered, and the resident was able to leave the secure dementia unit. During an interview with the DNS on 10/26/2021 immediately following the observation, she was unable to explain why the wander bracelet on the resident's ankle did not trigger the alarm inside the elevator. 4. Resident ID #8 was admitted to the facility in February 2021 with diagnoses that include, but are not limited to, dementia without behavioral disturbance and anxiety. Surveyor observation on 10/28/2021 at 10:00 AM revealed the resident in the common area with a wander guard on the right ankle. Record review of a quarterly MDS assessment dated [DATE] indicated the resident exhibited occasional wandering behaviors. Additionally, record review revealed a quarterly MDS assessment dated [DATE] that indicated the resident did not exhibit wandering behaviors. Further review of the physician's orders revealed an order dated 3/22/2021 which was discontinued on 7/21/2021 for wander bracelet check placement every shift. During an interview on 10/29/2021 at 2:00 PM with the Regional DNS, he was unaware that the resident had a wander guard bracelet on the ankle and could not explain why the bracelet was not removed upon discontinuation of the physician's order. 5. Resident ID #10 was admitted to the facility in May of 2020 with diagnoses that include, but are not limited to, Parkinson's disease and history of falling. Record review of the progress notes revealed the following: -progress note dated 8/23/2021 at 1:04 reads in part, Approx [approximately] 830pm Elder noted to be agitated and combative with staff. Elder set off alarm on door and was attempting to elope . -progress note dated 10/13/2021 at 8:29 reads in part.attempt to elope out of back elevator .waits until staff busy, then attempts to go to room [ROOM NUMBER], or out elevator . Review of the care plan failed to reveal evidence of a care plan for elopement behaviors. Further review of a wander/elopement risk evaluation dated 10/26/2021 revealed the resident did not have a history of eloping and was not at risk for elopement. During an interview with the resident on 10/29/2021 at 9:30 AM s/he stated s/he wished to leave the facility and go home to live with a relative. During an interview on 10/29/2021 at 2:00 PM with the DNS, she was unaware of the resident's prior elopement attempts and could not provide evidence of a care plan for elopement behaviors.

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F 0710 Level of Harm - Actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. 37158 Based on record review and staff interview, it has been determined that the facility failed to ensure that a physician, physician assistant, nurse practitioner, or clinical nurse specialist provide orders for the resident's immediate care needs and that the medical care of each resident is supervised by a physician for 1 of 12 residents reviewed for physician services, Resident ID # 2. Findings are as follows: 1. Record review for Resident ID #2 revealed s/he was admitted to the facility in August of 2021 with medical diagnoses including, but not limited to, diabetes mellitus, hyperlipidemia, acquired absence of right leg above the knee and left leg below the knee, chronic kidney disease, and cerebrovascular disease. Record review of the resident's liver function test (LFTs-blood tests used to help diagnose and monitor liver disease or damage) dated 9/20/2021, revealed the following baseline LFT laboratory values: -Alkaline Phosphatase (ALK) 95 normal range (42-121 U/L (units per liter) -Aspartate Aminotransferase (AST) 9 normal range (10-42 U/L) -Alanine Transaminase (ALT) 4 normal range (10-60 U/L) Further record review of the resident's subsequent LFTs obtained on the dates listed below revealed the following values which indicated that the LFT levels were progressively increasing: 10/4/2021 ALK 101 AST 13 ALT 9 10/11/2021 ALK 128 AST 65 ALT 54 10/14/2021 ALK 168 (continued on next page)

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F 0710 Level of Harm - Actual harm Residents Affected - Few	AST 176 ALT 143 10/18/2021 ALK 219 AST 351 ALT 224 Record review of the resident's order summary revealed the following current physician orders with a start date of 8/24/2021: - Rosuvastatin (a medication that can cause an increase in liver enzyme levels) 20 milligrams (mg) by mouth at bedtime for hyperlipidemia - Acetaminophen (a medication which is metabolized in the liver) 975 mg by mouth every 8 hours for pain/discomfort Record review of the October 2021 Medication Administration Record (MAR) revealed both Rosuvastatin and Acetaminophen continued to be administered, despite the increasingly elevated LFT levels, until the resident was discharged to an acute care hospital on 10/20/2021. Record review of a progress note dated 10/4/2021 at 3:07 PM, authored by the Nurse Practitioner (NP), Staff D, revealed he examined the resident's status, reviewed medications, and labs. Additionally, he indicated the resident was on Rosuvastatin for hyperlipidemia and stated, will monitor lfts . Record review of a progress note dated 10/11/2021 at 3:09 PM, authored by Staff D, revealed he examined the resident's status and reviewed his/her medications. Additionally, he indicated that lab values were also reviewed that day, and that the resident was on Rosuvastatin for hyperlipidemia and stated, will monitor lfts . Record review of a progress note dated 10/18/2021 at 4:05 PM, authored by Staff D, he revealed he examined the resident's status, reviewed the resident's medications and labs. Additionally, he indicated the resident was on Rosuvastatin for hyperlipidemia and stated, will monitor lfts . Further record review failed to reveal that any new orders for interventions were implemented to address the increasingly elevated LFT levels. Additionally, review of the resident's physician orders revealed an order for weekly CBC with differential (complete blood count-blood test to help diagnose and monitor different conditions) and CMP (Comprehensive Metabolic Panel-blood test used to evaluate liver function, kidney function, and nutrient levels) every Monday. (continued on next page)

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F 0710 Level of Harm - Actual harm Residents Affected - Few	Further review of the resident's laboratory report results dated 9/27/2021 revealed handwritten documentation at the bottom of the report which read, Repeat BMP [Basic Metabolic Panel-laboratory test that provides information on body's metabolism including kidney function and the balance of electrolytes] 9/30. Record review failed to reveal evidence that these laboratory results were ordered and/or obtained on 9/30/2021. Subsequent record review of the resident's laboratory report results from 10/14/2021 revealed handwritten documentation at the bottom of the report, which read, [check mark] CBC, CMP tomorrow. Record review failed to reveal evidence that these laboratory results were ordered and/or obtained on 10/15/2021. During an interview with the Director of Nursing Services on 10/29/2021 at approximately 4:40 PM, she was unable to provide evidence that the laboratory tests for 9/30/2021 and 10/15/2021 were obtained. Record review of a nursing progress note dated 10/20/2021 revealed the resident's BMP values, which were ordered and obtained that day, were reviewed by the physician. The note further revealed that based on the elevated creatinine levels, the physician ordered for the resident to be further evaluated at the hospital. Record review of the hospital continuity of care documentation dated 10/20/2021, revealed the resident's admitting diagnoses included, but were not limited to, acute liver failure, liver derangements (elevated INR, high LFTs), acute encephalopathy, and acute kidney injury. The LFT values were obtained at the hospital on 10/20/2021 and revealed the following: ALK 321 AST 464 ALT 277 During a surveyor interview on 10/28/2021 at 1:30 PM with Staff D, he revealed when he assesses a patient, he reviews the entire medication profile. Further stating that he was not aware the resident was on standing Acetaminophen, and he would have held this medication with the elevated LFT levels. Additionally, during a subsequent interview on 10/29/2021 at 2:07 PM with Staff D, he revealed that after reviewing the LFT values on 10/18/2021, he intended to give an order to hold the Rosuvastatin but failed to do so. During a surveyor interview with the resident's physician on 10/29/2021 at 1:52 PM, during which the LFT values were reviewed with him. The physician revealed that he was unaware of the resident's elevated LFT values over the last month and if he was aware, he would have discontinued both the Acetaminophen and Rosuvastatin medications.