STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445150	A. Building B. Wing	03/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Gardens at Memphis Rehab & Snc	131 N Tucker Memphis, TN 38104

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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 - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28913 Based on policy review, medical record review, and interview, the facility failed to provide the care and treatment of medications and wound treatments as ordered by the physician for 4 of 6 (Resident #9, #11, #14, and #16) sampled residents reviewed for medication and treatment administration. The findings included: 1. Review of the facility's policy titled Physician's Orders Policy dated 6/2017 and reviewed 1/2023, revealed . Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers that are received by a variety of methods . Review of the undated facility policy titled Medication Administration Schedule, revealed .Medications shall be administered according to established schedules . 2. Review of the medical record revealed Resident #9 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Type 2 Diabetes Mellitus, Peripheral Vascular Disease, Depression, Dementia Without Behavioral Disturbance, Atherosclerosis, and Delusional Disorders. Review of the physician's orders with a start date of 8/2/2022, revealed Levemir Solution 100 units/milliliter (ml) inject 40 units subcutaneously at bedtime, Lexapro tablet 10 milligrams (mg) by mouth at bedtime, Lipitor tablet 80 mg by mouth at bedtime, Melatonin tablet 5 mg by mouth at bedtime, Metformin tablet 500 mg give 750 mg by mouth two times a day, Xanax tablet 0.5 mg by mouth two times a day, Verapamil 40 mg by mouth three times a day. Review of the Medication Administration Record (MAR) for January 2023 revealed the physician's orders were not followed for medication administration on the following dates and times: a. 1/1/2023 - Levemir 100 units/ml at scheduled time of 8:00 PM. b. 1/7/2023 and 1/27/2023 - Lexapro 10 mg at scheduled time of 9:00 PM. c. 1/7/2023 and 1/27/2023 - Lipitor 80 mg at scheduled time of 9:00 PM. d. 1/7/2023 and 1/27/2023 - Melatonin 5 mg at scheduled time of 9:00 PM. e. 1/7/2023 - Metformin 500 mg at scheduled time of 5:00 PM. (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f. 1/7/2023 - Xanax 0.5 mg at scheduled time of 5:00 PM. g. 1/7/2023 - Verapamil 40 mg at scheduled time of 5:00 PM. During an interview on 3/14/2023 at 3:38 PM, when asked if the medications were administered as ordered by the physician, the Director Of Nursing (DON) stated, She [the nurse] either gave it and didn't chart it or it wasn't given. When asked if there was documentation the medications were administered, the DON stated, No, the initials are not there. Review of the physician's orders with a start date of 8/16/2022, revealed an order for Hydrocol II Thin Pad (wound dressing) apply to sacrum topically every three days. Cleanse area to sacrum with wound cleanser, pat dry, apply hydrocolloid dressing, change every 3 days and as needed. Review of the Treatment Administration Record (TAR) for December 2022, January 2023 and March 2023 revealed the physician's orders were not followed for wound care treatments on the following dates: a. 12/30/2022 - no documentation of treatment at scheduled time of 9:00 AM. b. 1/2/2023, 1/19/2023, 1/22/2023, and 1/28/2023 - no documentation of treatment at scheduled time of 9:00 AM. c. 3/2/2023 - no documentation of treatment at scheduled time of 9:00 AM. During an interview on 3/13/2023 at 12:05 PM, when asked if Resident #9 received the treatments as ordered on 12/30/2022, 1/2/2023, 1/19/2023, 1/22/2023, and 1/28/2023 Licensed Practical Nurse (LPN) #4 stated, .I can't say, but there are no initials that it was done .I was here. I guess I just forgot. 3. Review of the medical record revealed Resident #11 was admitted to the facility on [DATE] with diagnoses of Type 2 Diabetes Mellitus, Peripheral Vascular Disease, Diabetic Right Plantar Foot Wound, Chronic Neuropathy, Chronic Kidney Disease, Essential Hypertension, Insomnia, and Acute Osteomyelitis Right Ankle and Foot. Review of the admission Minimum Data Set (MDS) dated [DATE], revealed Resident #11 scored 13 on the Brief Interview of Mental Status (BIMS) which indicated no cognitive impairment. Review of the physician's orders with a start date of 12/19/2022, revealed an order for Atorvastatin Calcium tablet 40 mg by mouth at bedtime, Amlodipine 10 mg by mouth one time a day, Aspirin capsule 81 mg by mouth one time a day, Losartan Potassium tablet 50 mg by mouth two times a day, Saccharomycin capsule 250 mg by mouth two times a day, Trazodone tablet 50 mg by mouth at bedtime, and apply Silver External Pad to right plantar topically every 3 days. Cleanse area to right plantar with wound cleanser, pat dry, apply silver alginate with collagen, kerlix wrap every 3 days. Review of the MAR for January 2023 revealed the physician's orders were not followed for medication administration on the following dates and times: a. 1/1/2023 - Amlodipine 10 mg at scheduled time of 9:00 AM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. 1/1/2023 - Aspirin 81 mg at scheduled time of 9:00 AM. c. 1/1/2023 and 1/7/2023 - Atorvastatin Calcium 40 mg at scheduled time of 8:00 PM. d. 1/1/2023 and 1/7/2023 - Trazodone 50 mg at scheduled time of 8:00 PM. e. 1/1/2023 - Losartan Potassium 50 mg at scheduled time of 9:00 AM and 5:00 PM. f. 1/1/2023 - Saccharomycin 250 mg at scheduled time of 9:00 AM and 5:00 PM. During an interview on 3/14/2023 at 3:38 PM, when asked if the medications were administered as ordered by the physician on the dates listed, the DON confirmed there was no documentation the medications were administered. Review of the TAR for December 2022 and January 2023, revealed the physician's orders were not followed for wound care treatments on the following dates and times: a. 12/24/2022 - no documentation of treatment at scheduled time of 9:00 AM. b. 12/30/2022 - no documentation of treatment at scheduled time of 9:00 AM. c. 1/9/2023, 1/15/2023, 1/19/2023, and 1/21/2023 - no documentation of treatment at scheduled time of 9:00 AM. During a telephone interview on 3/13/2023 at 12:25 PM, when asked if he received the medications that had been ordered by the physician, Resident #11 stated, They didn't give me my medicine .They didn't change my dressing to the wound like it was ordered . 4. Review of the medical record revealed Resident #14 was admitted to the facility on [DATE] with diagnoses of Dementia, Fracture of Nasal Bones, Fracture of One Rib Left Side, Fracture of Fifth Lumbar Vertebra, Depression, Contusion of Lung Bilateral, Neuropathy, Insomnia, and Car Driver Injured in [NAME]. Review of the physician's orders with a start date of 9/22/2022, revealed an order for Melatonin tablet 3 mg give 3 tablets by mouth at bedtime, Quetiapine Fumarate tablet 100 mg by mouth at bedtime, Trazadone tablet 100 mg by mouth at bedtime, and Gabapentin capsule 300 mg by mouth every 8 hours. Review of the MAR for October 2022, revealed the physician's orders were not followed for medication administration on the following dates and times: a. 10/2/2022 - Melatonin 9 mg at scheduled time of 8:00 PM. b. 10/2/2022 - Quetiapine Fumarate 100 mg at scheduled time of 8:00 PM. c. 10/2/2022 - Trazodone 100 mg at scheduled time of 8:00 PM. e. 10/2/2022 and 10/4/2022 - Gabapentin 300 mg at scheduled time of 6:00 AM and 10:00 PM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of the medical record revealed Resident #16 was admitted to the facility on [DATE] with diagnoses of Type 2 Diabetes Mellitus, Cerebrovascular Disease, Dementia, Atrial Fibrillation, Heart Failure, Essential Hypertension, and Psoriasis. Review of the current physician's orders dated 9/14/2022, revealed Aldactone tablet 25 mg by mouth one time a day, Atorvastatin Calcium tablet 40 mg by mouth one time a day at bedtime, Dapagliflozin Propanediol Tablet 5 mg by mouth one time a day, Ferrous Sulfate 325 mg by mouth at bedtime, Extended Release Isosorbide Mononitrate tablet 30 mg by mouth one time a day, Lasix tablet 40 mg by mouth one time a day, Multivitamin tablet by mouth one time a day, Pantoprazole Sodium tablet 40 mg by mouth one time a day, Remeron tablet 15 mg by mouth at bedtime, Sertraline tablet 50 mg one time a day, Tradjenta tablet 5 mg one time a day, Apixaban tablet 5mg by mouth two times a day, Hydralazine tablet 25 mg by mouth two times a day, and Metoprolol Tartrate tablet 25 mg by mouth two times a day. Review of the physician's order dated 1/3/2023, revealed Enteric Coated Aspirin 81 mg by mouth one time a day, Review of the MAR for January 2023, revealed the physician's orders were not followed for medication administration on the following dates and times: a. 1/9/2023 - Aldactone 25 mg at scheduled time of 9:00 AM. b. 1/9/2023 - Aspirin 81 mg at scheduled time of 9:00 AM. c. 1/5/2023 and 1/8/2023 - Atorvastatin Calcium 40 mg at scheduled time of 8:00 PM. d. 1/3/2023 and 1/9/2023 - Dapagliflozin Propanediol 5 mg at scheduled time of 9:00 AM. e. 1/5/2023 and 1/8/2023 - Ferrous Sulfate 325 mg at scheduled time of 8:00 PM. f. 1/3/2023 and 1/9/2023 - Isosorbide Mononitrate 30 mg at scheduled time of 9:00 AM. g. 1/3/2023 and 1/9/2023 - Lasix 40 mg at scheduled time of 9:00 AM. h. 1/3/2023 and 1/9/2023 - Multivitamin at scheduled time of 9:00 AM. i. 1/3/2023, 1/6/2023, 1/9/2023 and 1/15/2023 - Pantoprazole Sodium at scheduled time of 6:30 AM. j. 1/5/2023 and 1/8/2023 - Remeron 15 mg at scheduled time of 8:00 PM. k. 1/3/2023 and 1/9/2023 - Sertraline 50 mg at scheduled time of 9:00 AM. l. 1/3/2023 and 1/9/2023 - Tradjenta 5 mg at scheduled time of 9:00 AM. m.1/3/2023, 1/5/2023, 1/8/2023 and 1/9/2023 at scheduled times of 9:00 AM and 5:00 PM. n. 1/3/2023, 1/5/2023, 1/8/2023, 1/9/2023 - Hydralazine 25 mg at scheduled times of 9:00 AM and 5:00 PM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o. 1/3/2023, 1/5/2023, 1/8/2023, and 1/9/2023 - Metoprolol Tartrate 25 mg at scheduled time of 9:00 AM and 5:00 PM. Review of the MAR for February 2023, revealed the physician's orders were not followed for medication administration on the following dates: a. 2/19/2023 - Apixaban 5 mg at scheduled time of 5:00 PM b. 2/19/2023 - Hydralazine 25 mg at scheduled time of 5:00 PM c. 2/19/2023 - Metoprolol Tartrate 25 mg at scheduled time of 5:00 PM Review of the MAR for March 2023, revealed the physician's orders were not followed for medication administration on the following date and time: a. 1/7/2023 - Pantoprazole Sodium at scheduled time of 6:30 AM. Review of the physician's orders with a start date of 2/13/2023, revealed an order for Hydrofoil External pad apply to sacral area topically every day shift every 3 days. Review of the physician's orders with a start date of 2/11/2023, revealed an order for Skin Prep wipe apply to left lateral ankle topically every dayshift. Review of the TAR for March 2023 revealed the physician's orders were not followed for wound care treatments on the following dates: a. 2/28/2023 - no documentation of treatment to sacral area. b. 2/28/2023 - no documentation of treatment to left lateral ankle. During an interview on 3/14/2023 at 3:41 PM, when asked if the treatments had been administered as ordered by the physician, the DON stated, Not done or not charted .It will show up in computer not done. We primarily focus on medications. I guess we need to focus on TARs as well.

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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** 29706 Based on policy review, facility investigation review, medical record review, observation, and interview, the facility failed to ensure a safe environment, provide adequate supervision, and accurately assess a severely cognitively impaired resident with Dementia, confusion and a history of wandering to prevent elopement for 1 of 14 sampled residents (Resident #1) reviewed with wandering behaviors and elopement. Resident #1 eloped from the facility on 1/2/2023 at approximately 1:15 PM, walked across the employee back parking lot and was found near the street. The Weather History web site revealed the recorded temperature for Memphis, TN on 1/2/2023 at 4:00 PM, was 65 degrees Fahrenheit and raining. Resident #1 was unsupervised outside the building without staff knowledge, which resulted in Immediate Jeopardy (IJ) for Resident #1. The facility failed to conduct accurate assessments that ensured a safe environment, provide adequate supervision, and accurately assess 14 of 14 (Residents #1, #4, #6, #7, #8, #10, #12, #18, #19, #20, #21, 23, 24, and #25) residents reviewed with wandering and/or elopement behaviors. Immediate Jeopardy (IJ) (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified related to the facility's failure to supervise a severely cognitively impaired resident with Dementia, confusion, and a history of wandering behaviors, which resulted in Resident #1's elopement. The facility's failure placed Resident #1 in Immediate Jeopardy. The Administrator and Director of Nursing (DON) were notified of the Immediate Jeopardy on 3/15/2023 at 2:16 PM in the Conference Room. F-689 was cited at a scope and severity of J which is Substandard Quality of Care. The IJ was effective 1/2/2023 and is ongoing. The findings include: 1. Review of the facility's Wandering, Unsafe Resident policy initiated 6/2017 and reviewed 1/2023, revealed, .The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement .The staff will identify residents who are at risk for harm because of unsafe wandering. The staff will assess at-risk individuals for potentially correctable risk factors related to unsafe wandering. The resident's care plan will indicate the resident is at risk for elopement or other safety issues. Interventions to try to maintain safety will be included in the resident's care plan. Nursing staff will document circumstances related to unsafe actions, including wandering, by a resident. Staff will institute a detailed monitoring plan, as indicated for residents who are assessed to have a high risk of elopement or other unsafe behavior. Staff will notify the Administrator and Director of Nursing immediately and will institute appropriate measures [including searching] for any resident who is discovered to be missing from the unit or facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Wandering Risk Screen system revealed a computerized assessment system (Point Click Care) that listed applicable sections titled, Orientation, Behavior/Mood, Recent Experiences, Mobility, Diagnosis, Medications, and History of Wandering. Based on the accuracy of the data entered by the nurse, the system would designate the resident's level for unsafe wandering risk. Review of the facility's Wander Guard Policy policy initiated 6/2017 and reviewed 1/2023 revealed, Wander Guards are put in place to detect when a resident is near a protected exit and alert staff. The exit can then be secured, or the resident can be assisted by a member of staff. Placement of wander guards are determined through nursing assessment and can be added once exit seeking behavior is observed at any time after admission. All wander guards require a physician order for implementation. Weekly monitoring of wander guards and doors equipped with wander guard system. Residents at risk of wandering wear a wrist or ankle transmitter or tag which allows them free movement within the facility but prevents them from exiting monitored doors. Current system is configured to create an audible alert at the door where resident is attempting to exit that has a wander guard on their person. Wander guard is also integrated with Access Control so that the door will lock as the resident approaches and unlock again as they move away from the area. Review of the facility's Admission/Assessment Policy policy dated 4/1/2020 and reviewed 1/5/2023 revealed, Facility shall complete resident assessment upon admission. Residents shall be assessed by nurse and complete a head to toe evaluation including all systems upon admission. Nurse shall complete following assessments: Wandering .Baseline Care plan shall be created within 48 hours of admission based on admission assessments. Appropriate interventions shall be provided to ensure resident safety and maintain functional independence .Nursing shall document admission assessment findings in EMR [electronic medical record] .Wander Guard Orders/Elopement Risk and Documented on Medical Record [if applicable] . 2. Review of the hospital's History and Physical (which was dated 12/19/2022) and received by the facility upon the Resident #1's admission on 12/30/2022 revealed Resident #1, .lived with [his] nephew .fell at home few times .more confused with periods of sundowning and wandering at night . Resident #1 had diagnoses that included Dementia with Behaviors, Diabetes Mellitus Type 2, Syncope and Collapse. Review of Resident #1's Admit/Readmit Information that included the Wandering Risk assessment dated [DATE], revealed there was no documentation the resident's known history of wandering was included. Review of the Instant Care Plan dated 12/30/2022, revealed no documentation Resident #1 had Dementia or wandering behaviors. Review of the Nurse Practitioner note dated 12/30/2022, revealed Resident #1 was had previously been a patient at, .[named hospital] after fall at home .Dementia with increased confusion and sundowning . Review of the physician's order dated 12/31/2022, revealed, .Trazadone HCL [Hydrochloride] [an antidepressant/sedative medication] oral tablet 50 mg [milligrams] give 1 tablet by mouth at bedtime for depression . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Wandering Risk Screen assessment dated [DATE], revealed Resident #1's scored was an 8, which indicated a moderate risk for wandering. There was no documentation in the screen assessment of the resident having the diagnosis of Dementia or the antidepressant medication of Trazadone. Review of the Nurse's notes dated 1/2/2023 at 4:43 PM, revealed, .1322 [1:22 PM] noted pt [Resident #1] not in his room on nurse rounds. last visual on pt was at 1315 [1:15 PM] by nurses in report. Staff sent to check the therapy gym, 100 hall sunroom therapy gym, pt not found. Code Purple [Alert for a missing resident] initiated [at approximately 4:30 PM per Certified Nursing Assistant (CNA) #3's interview] .Pt located by staff approx 1,000 ft [feet] from the building, he was noted alert and w/o [without] s/s [signs and symptoms] of distress and no visual injuries noted. Pt escorted back to the building and was placed on the 400 hall in room [ROOM NUMBER] . Based on the Memphis, TN Weather History web site, the recorded temperature for Memphis, TN on 1/2/2023 at 4:00 PM was 65 degrees Fahrenheit and raining. Review of the Nurse's notes dated 1/2/2023 at 7:39 PM, revealed, Pt wandering in the halls. Wander guard [a sensor alarm system worn by residents to alert staff if a resident attempts to exit through monitored exit doors] placed to the R [right] ankle for safety . During an interview on 3/15/2023 at 8:36 AM, Registered Nurse (RN) #2 was asked when the wander guard was placed on Resident #1. RN #2 stated, .After the elopement I put the wander guard on, not before . Review of the facility's investigation dated 1/3/2023 of Resident #1's elopement on 1/2/2023, revealed the facility reviewed a video (Camera #1) showing the resident exiting the building through the 100 hall unit door out to a courtyard area and rounded the corner. Camera #1 lost view after the resident rounded the corner. Another camera (Camera #2) positioned at the ambulance door aimed at the back parking lot revealed Resident #1 walking toward the street. The ambulance door camera (Camera #2) then lost sight of Resident #1. The facility's investigation documentation revealed he was found outside on the sidewalk beside the street, a 1,000 feet from the building. The facility documented Resident #1 exited the courtyard either thru a gap between a chain link fence and gate (that was loosely locked with a bike type rope lock) or through a gap that was between the chain link fence and the building wall. The facility failed to save the video as part of the investigation and did not include a summary of the video with times and locations in the investigation. The surveyor was unable to view the video and the Administrator did not keep notes from review of the video. During an interview on 3/6/2023 at 12:53 PM, RN #2 stated, .[Resident #1] would walk around a lot, walk to the Friendship corner, sit in the lobby, anywhere there was a TV .[Resident #1] would look at .[Resident #1] would ask why was he here, where is the food, who paid for him to be here, what were we going to do for him .When we couldn't find him [Resident #1] we called a Code Purple and looked everywhere inside the building then looked outside .I can't remember what time I found him on the far side of the back employee parking lot located near the street and the apartments .Resident #1 was walking and looking left and right like didn't know where to go, not sure .Just me and him I don't remember any other staff around when I found him. Resident #1 had on pants and a shirt .It was a little rainy, wet but not cold .I called his name and he said 'Hey baby I'm glad to see you'. I told [Resident #1] let's go back inside and he went with me with no problems . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 3/6/2023 at 3:04 PM, CNA #1 stated, .I came to work on 200 hall about 3:12 PM to 3:25 PM and was in room [ROOM NUMBER] and looked out the window facing [name of the street, a two lane neighborhood street entering to a busy 6 lane major street] and saw a tall male standing on the sidewalk wearing blue sweatshirt and match blue pants with yellow socks, dark shoes like brown/black house slippers and had a Reacher [a reaching device to maintain independence] hanging on his left arm .[Resident #1] was facing the employee parking lot looking around. He had a clear plastic bag [trash bag] with eyes poked out over his head .the fire department truck was across the street at those [NAME] apartments .An aide told me a person was missing. I said on [Name of the street] .Me [CNA #1] and another employee then got in my truck and started driving slow around to try and find him .I was driving slow and looking everywhere as we drove .It was misting rain and you needed long sleeves .We turned right from the parking lot and drove up to [Name of a busy street] and over to [Name of another street] .when we got a call all clear patient [Resident #1] located outside . During an interview on 3/7/2023 at 3:20 PM, CNA #3 stated, .[On 1/2/2023] I work three to eleven and I was here at 3:00 PM. I saw him [Resident #1] standing at the double door in the lobby between 100 hall and the lobby. He [Resident #1] said I am trying to go to [name of a street] street. I said ok well, let me go down here and see what is going on. I came back up front and he [Resident #1] was gone .It was about 4:30 PM when Code Purple was paged .It was around 6:00 PM before tray pass when someone said he was found in the basement .I never saw him [Resident #1] again that day . The admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1's Brief Interview of Mental Status (BIMS) score was 4, which indicated Resident #1 had severely impaired cognition for daily decision making. Continued review revealed Resident #1 had an unsteady gait and could stabilize without staff assistance. Review of the Wander Guard Bracelet Weekly Inspection form dated January 2023 through March 2023, revealed no documentation Resident #1's wander guard functionality had been inspected in accordance with the facility's wander guard policy. During an interview on 3/7/2023 at 1:40 PM, DON stated, .Maintenance does the resident's wander guard functionality inspection weekly .No, I don't see any documentation where [Named Resident #1] wander guard was inspected for functionality . During an interview on 3/7/2023 at 1:46 PM, the Administrator was asked if there was any documentation of [Resident #1's] wander guard functionality being checked January, February, and March 2023. He stated, .I don't see it .that's all I have, do what you got to do . Observations on 3/8/2023 at 1:30 PM, revealed the 2nd floor activity room/office was unlocked and unattended, and there were residents in the hallway near the entrance. In the activity room/office was another door that led to the roof top of the facility. The door that led onto the facility roof top was not locked and had no alarms to signal when opened. Observations of exit door #9 located between resident dining room and Therapy gym on 3/15/2023 at 11:34 AM, revealed the door opened with employee badge and would remain unlocked until someone could activate the door lock button located on the left top frame of the door. Continued observations revealed the Administrator stated to the employee, .Be sure you press the red button to lock once you go through . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observations of exit door #11, with an indicating exit sign above, located on the 200 hall near the nurse's station on 3/15/2023 at 11:40 AM, revealed the door was not latched and ajar (slightly open) no alarm sounding. This exit door leads to a stair well and to an outside exit door that is not locked and does not alarm when opened. Observations on 3/15/2023 at 11:55 AM revealed exit door #19, with an indicating exit sign above, located on the 2nd floor Memory Care Unit the revealed door was opened by an employee with an employee badge, did not latch, and stayed unlocked with green light on. This exit door leads to a stair well and to an outside exit door that is not locked and does not alarm when opened. During an interview on 3/14/2023 at 1:55 PM, the Maintenance Director stated, .We have two doors that have the wander guard system. The front door and the ambulance entry door .they are the only doors that can detect the wander guard . During an interview on 3/15/2023 at 1:00 PM, the Administrator stated, .That's [doors] definitely got to be fixed .this old building when the weather changes sometimes have to shave the door, things like this . 4. Review of the medical record revealed Resident #4 was admitted to the facility on [DATE] with a diagnosis of Dementia with Psychosis. Review of Resident #4's care plan dated 1/18/2023 revealed there was no documentation of the resident's wandering behaviors. Review of the physician's order dated 1/18/2023 revealed, .Oxycodone Acetaminophen 5-325 mg [a narcotic medication to treat pain] 1 by mouth every 4 hours prn [as needed] for pain . Review of the admission Wander Risk assessment dated [DATE], revealed Resident #4 scored a 10 indicating moderate risk for wandering. There was no documentation the assessment included the resident's diagnosis of Dementia, and narcotic medication prescribed. Review of the Resident #4's admission MDS assessment dated [DATE], revealed Resident #4 scored a 11 on the BIMS assessment which indicated moderately impaired cognition. The assessment documented Resident #4 had the behaviors of wandering 1 to 3 days of the assessment period. Review of the maintenance record Wander Guard Bracelet Weekly Inspection dated 3/10/2023, revealed there was no documentation that Resident #4's wander guard functionality had been tested . Observations in Resident #4's room on 3/8/2023 at 1:45 PM, revealed Resident #4 to be sitting in a chair, alert and oriented to self, wander guard device on left ankle. 5. Review of the medical record revealed Resident #6 was admitted to the facility on [DATE] with diagnoses Dementia with Behaviors, Anxiety and Alcohol Dementia. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Nurse's note dated 1/18/2023 at 7:55 PM, revealed .Resident [#6] arrived by stretcher with 3 EMT [Emergency Medical Technician] at side upon enter building resident unfasten belt to stretcher and jumped off stretcher. Staff and EMTs caught resident. Resident became violent started swinging and trying to hit staff and EMTs. They assisted resident to room [Resident #4's room number] he started stripping all clothing off, refused to allow staff to place gown on, continued to try and ambulate out of the room, gait very unsteady. Resident AAO x1 [alert, oriented] name only .limited assist with ambulation. Independent with bed mobility and transfer .resident continued to try and ambulate throwing bed sheets and pillows on floor . The admission Minimum Data Set (MDS) 1/25/2023, documented the resident scored a 0 on the BIMS indicating the resident had severely impaired cognition for daily decision making. The assessment documented the resident had the behaviors of wandering 1 to 3 days during the assessment period. Review of the Care Plan dated 1/18/2023, revealed there was no documentation of a wandering/elopement risk. Review of the admission Wander Risk assessment dated [DATE], revealed Resident #6 scored a 13 which indicated a high risk for wandering. There was no documentation the assessment included the resident's diagnosis of Dementia. 6. Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] with diagnoses of Dementia Without Behavioral Disturbance, End Stage Renal Disease, Dependence on Renal Dialysis, and Essential Hypertension. Review of the hospital History and Physical dated 10/31/2022, received by the facility upon admission, revealed .the patient [Resident #7] has wandered off. Family with concerns regarding the patient's confusion, anxiousness and wandering off . Review of the Instant Care Plan dated 11/16/2022 revealed there was no documentation the care plan included the resident had Dementia or wandering behaviors. Review of the Wandering Risk Screen dated 11/17/2022, revealed Resident #7 scored a 3 which indicated a low risk for wandering. There was no documentation the screen/assessment included the resident having the diagnosis of Dementia and known history of wandering. Review of the Wandering Risk Screen dated 1/4/2023 revealed there was no documentation the screen was completed. Review of a Plan of Care Note dated 1/8/2023, revealed .[Named Resident #7] has packed his clothes and shoes this morning. He stated that he is going to leave the facility. He began walking toward the exit door with his belongings .[Resident #7] has a wander-guard placed on lower extremity . Record review revealed there was no order for a wander guard for Resident #7 and there was no documentation the facility had determined the wander guard functionality. Review of the Care Plan dated 2/7/2023, revealed .Resident was seen by this nurse and a CNA walking towards the side door to outside with a bag in his hand and his cane . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the comprehensive care plan with a target date of 5/13/2023, revealed there was no documentation Resident #7 had behaviors of wandering or the use of a wander guard device. Review of the quarterly MDS assessment dated [DATE], revealed Resident #7 scored a 10 on the BIMS assessment which indicated moderately impaired cognition. The resident required limited assistance for ambulation. Resident #7 had an unsteady gait and could stabilize without staff assistance. Observations in the resident's room on 3/8/2023 at 9:59 AM, revealed Resident #7 was seated on the side of the bed and transferred himself to a standing position. A wander guard was in place on the resident's right ankle. He ambulated independently in his room using a cane. The resident stated, I like to walk to the door every morning and would go out, but they put this thing [wander guard] on my leg . During an interview on 3/7/2023 at 2:38 PM, when asked if Resident #7 had a wander guard placed due to wandering/exit seeking behaviors, The DON stated, No one has ever told me he was a wanderer .He doesn't have a wander guard. During an interview on 3/14/2023 at 8:55 AM, when asked if there were any residents on the 100 hall with a wander guard in place, LPN #1 stated, I don't have any resident with a wander guard that I'm aware of . Resident #7 resided on the 100 hall. 7. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE] with diagnoses of Cerebral Infarction, Depression, End Stage Renal Disease, Dependence on Renal Dialysis, Aphasia, Essential Hypertension, and Lack of Coordination. Review of the Admission Summary dated 2/14/2023, revealed .Pt [patient, (Resident #8)] is ambulatory and has some confusion, wander guard to R [right] ankle placed . Review of the Admit/Readmit Information assessment dated [DATE], revealed there was no documentation of the resident's cognitive status and taking antidepressants was included in the assessment. Resident #8 had a physician's order dated 2/15/2023 for Zoloft 50 mg daily (an antidepressant medication). The wandering risk assessment was not revised to reflect the Zoloft medication. Review of the Wandering Risk Screen dated 2/15/2023, revealed Resident #8 scored a 4 which indicated a low risk for wandering. The screen/assessment revealed the resident's history of wandering was not included in the screen. Review of the physician's orders dated 2/18/2023, revealed .Check Placement of Wander Guard to right ankle every shift for wandering . Continued review revealed there was no documentation the facility had determined the wander guard was functioning properly. Review of the Plan of Care Note dated 2/18/2023, revealed .Resident is displaying exit seeking behavior. Packing up his belongings and continuing to walk up to exit doors with belongings in his hand . Review of the admission MDS assessment dated [DATE] revealed Resident #8 scored a 6 on the BIMS assessment which indicated severely impaired cognition. The resident required supervision with ambulation and had an unsteady gait and needed staff assistance to stabilize. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Plan of Care Note dated 2/22/2023, revealed Resident #8 was .pacing facility with his belongings in his arms trying to exit facility. Attempted to reorient patient [Resident #8], was unsuccessful . Review of the Wandering Risk Screen dated 2/27/2023, revealed an inaccurate assessment. The screen/assessment did not include the resident's history of wandering. Review of the Plan of Care Note dated 2/27/2023, revealed .resident in the front lobby telling the receptionist that he needed to get out of this place . Observations in the resident's room on 3/13/2023 at 3:25 PM, revealed Resident #8 walking in his room. There was a wander guard on his left ankle. During an interview on 3/13/2023 at 3:29 PM, when asked if Resident #8 had behaviors of wandering and a wander guard placed, RN #4 stated, I don't know. He came to this floor [300 Hall] yesterday. 8. Review of the medical record revealed Resident #10 was admitted to the facility on [DATE] with diagnoses of Cerebrovascular Disease, Delirium, Hypertension and Encephalopathy. Review of physician's orders with a start date 10/18/2022 revealed, .Wander guard monitoring: wander guard on at all times check placement every shift . Review of physician's orders with a start date 10/19/2022 revealed, .Quetiapine Fumarate 50 mg [an antipsychotic medication] 1 by mouth twice daily for psychotic disorder with delusions . The quarterly MDS dated [DATE] documented the resident scored an 8 on the BIMS assessment which indicated moderately impaired cognition for daily decision making. Review of the Wandering Risk Screen dated 1/3/2022 revealed a score of NA (not applicable) low risk, there was no documentation the screen was completed. Review of the maintenance record Wander Guard Bracelet Weekly Inspection dated February and March 2023 revealed there was no documentation of Resident #10's wander guard functionality tested . Observations in room [ROOM NUMBER] B on 3/8/2023 at 1:26 PM revealed Resident #10 lying in bed, alert and oriented to self, wander guard on left ankle. During an interview on 3/13/2023 at 1:19 PM, the Director of Nursing (DON) confirmed Resident #10's wandering risk screen dated 1/3/2023 was not completed. He stated, .all the areas are blank .It is not completed .This was when we were to review all residents on 1/3 [1/3/2023] and 1/4 [1/4/2023] as part of our performance improvement plan .It should have been completed . 9. Review of the medical record revealed Resident #12 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Dementia Without Behavioral Disturbance, Bipolar Disorder, Schizoaffective Disorder, Personality Disorder, and Type 2 Diabetes Mellitus. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the quarterly MDS assessment dated [DATE] revealed Resident #12 scored a 10 on the BIMS assessment which indicated moderately impaired cognition. The resident required limited assistance with ambulation. Resident #12 had an unsteady gait and was able to steady self without staff assistance. Review of the Admit/Readmit Information assessment dated [DATE] revealed an inaccurate assessment. The wandering risk assessment section had no documentation of the resident's diagnosis of Dementia. Review of the Admit/Readmit Information assessment dated [DATE] revealed a score of 2 which indicated low risk for wandering. The assessment revealed there was no documentation of the resident's diagnosis of Dementia. Review of the Wandering Risk Screen dated 1/3/2023 revealed no documentation the screen/assessment was completed. Observation in the resident's room on 3/7/2023 at 2:21 PM revealed Resident #12 was not in her room or in the hallway near her room. During an interview on 3/7/2023 at 2:23 PM, when asked where Resident #12 was, LPN #3 stated, I don't know where she is. She is somewhere. She goes around the halls all the time. When asked if the resident had any exit seeking behaviors, the LPN stated, Leave? She might try. She is very confused and has random thoughts . 10. Review of the medical record revealed Resident #18 was admitted to the facility on [DATE] with diagnoses Alzheimer's Disease and Dementia without Behaviors. Review of Resident #18's Wandering Risk Screen dated 1/13/2023 revealed the resident had a known history of wandering. Review of physician's orders with a start date 1/25/2023 revealed, .Wander guard in place every shift for wandering . The admission MDS 1/26/2023 documented the Resident #18 scored a 2 on the BIMS assessment which indicated severely impaired cognition for daily decision making. Review of the care plan dated January 2023 revealed Resident #18 had wandering behaviors with wander guard. Review of Resident #18's MARs dated February through March 2023 revealed the wander guard in was place every shift for wandering was checked as completed on all shifts every day. Review of the maintenance record Wander Guard Bracelet Weekly Inspection revealed on 2/3/2023, 2/17/2023, 3/3/2023 and 3/10/2023 no tag was marked as resident not having a wander guard. Continued review revealed on 2/24/2023 the pass/fail was marked related to Resident #18's wander guard. During an interview on 3/14/2023 at 1:45 PM the Maintenance Assistant was asked about the wander guard bracelet weekly inspection report. The Maintenance Assistant stated . ' no tag ' means not on him .I told nurse [named person] he didn't have one [wander guard] on . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observations on 3/14/2023 at 9:30 AM, revealed Resident #18 had no wander guard on. During an interview on 3/14/2023 at 9:30 AM, CNA #2 confirmed Resident #18 had no wander guard. She stated, .no, he doesn't have one [wander guard] on . 11. Review of the medical record revealed Resident #19 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of Dementia without Behaviors, Diabetes Mellitus Type 2, Anxiety, and Major Depression. The quarterly MDS 2/4/2023 for resident #19 documented the resident scored a 5 on the BIMS which indicated severely impaired cognition for daily decision making. Review of the physician's orders with a start date 7/29/2022 revealed .Buspirone HCL 10 mg [medication for anxiety] 1 by mouth twice daily anxiety .Escitalopram Oxalate 10 mg [a medication to treat depression and anxiety] 1 by mouth every am .Trazodone HCL 50 mg [antidepressant] give 25 mg by mouth at hs [bedtime] depression . Review of the physician's orders with a start date 11/30/2022 revealed .Wander guard in place every shift for Wandering . Review of the Wandering Risk Screen dated 1/3/2023 revealed Resident #19 scored a 2 which indicated a low risk for wandering. There was no documentation in the screen/assessment that included the resident's diagnosis of Dementia, no documentation the medications for depression or anxiety were included, and no documentation of the resident's history of wandering included in the screen assessment. Review of Resident #19's MARs dated February and March 2023, revealed Wander guard in place every shift for wandering was checked as completed on all shifts every day. Review of the maintenance record Wander Guard Bracelet Weekly Inspection dated 3/10/23, revealed .pass . During an interview on 3/14/2023 at 1:45 PM, the Maintenance assistant revealed, .pass means they had a wander guard on, and it passed the test . Observations on 3/14/2023 at 9:35 AM, revealed Resident #19 with had no wander guard on. During an interview on 3/13/2023 at 1:19 PM, the DON confirmed Resident #19's wandering risk screen dated 1/3/2023 was not accurate. He stated, .some areas are blank .It is not accurate .This was when we were to review all residents on 1/3 and 1/4 as part of our performance improvement plan .It should have been completed correctly . During an interview on 3/14/2023 at 9:35 AM, CNA #2 confirmed Resident #19 did not have a wander guard. She stated, .No, he doesn't have one [wander guard] on . 12. Review of the medical record revealed Resident #20 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses Dementia with Agitation and Psychotic Disorder with Delusions. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The quarterly MDS 2/9/2023 documented the resident scored a 3 on the BIMS which indicated severely impaired cognition for daily decision making. Review of the physician's orders dated 8/29/2022 revealed, .Seroquel oral tab 50 mg 1 by mouth hs . Review of the physician's orders dated 12/6/2022 revealed, .Wander guard in place . Review of the Wandering Risk Screen dated 1/3/2023 revealed Resident #20 scored a 2 which indicated a low risk for wandering. There was no documentation the resident's orientation, behavior/mood, diagnosis of Dementia, Seroquel medication, or history of wandering was included in the screening. Review of the physician's orders dated 3/9/2023 revealed, .check wander guard function every week . Review of the care plan revision dated 3/28/2022 revealed, .is an elopement risk wanderer .wander alert wander guard per MD orders . Review of Resident #20's MARs dated February 2023[TRUNCATED]

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28913 Based on policy review, medical record review, observation, and interview, the facility failed to follow the facility's policy for hydration and failed to manage the residents' hydration needs/preferences for 7 of 10 (Resident #9, #16, #26, #27, #28, #29, and #30) sampled residents reviewed for hydration. The findings included: 1. Review of the facility's policy titled Resident Hydration and Prevention of Dehydration dated March 2013 and revised January 2023, revealed .This facility will endeavor to provide adequate hydration and to prevent and treat dehydration .Nurses' Aides will provide and encourage intake of bedside, snack and meal fluids, on a daily and routine basis as part of daily care. Intake will be documented in the medical records. Aides will report intake of less than 1200 ml [milliliters]/day to nursing staff .Nursing will monitor and document fluid intake . 2. Review of the medical record revealed Resident #9 was initially admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses of Type 2 Diabetes Mellitus, Dysphagia, Peripheral Vascular Disease, Major Depression, Dementia Without Behavioral Disturbance, and Delusional Disorders. Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 5 which indicated severe cognitive impairment. The resident needed extensive assistance for activities of daily living and was dependent upon staff for transfers. Review of the physician's orders dated 2/3/2023, revealed an order for a regular diet with pureed texture foods with nectar thick consistency for liquids and enteral nutrition via pump of Glucerna 1.5 at 90 milliliters/hour for 12 hours and water flush of 45 cubic centimeters/12 hours. Observations in the resident's room on 3/27/2023 at 12:35 PM, revealed Resident #9 was alert with confusion, attempting to transfer herself out of the bed. There were 3 unopened nectar thick consistency juice containers on the overbed table which was out of reach of the resident. There was one container opened which remained full. Observations in the resident's room on 3/27/2023 at 2:15 PM, revealed the same 3 unopened containers of juice and one container opened and remained full. Another container of juice had been brought in the room, left unopened and out of reach on the overbed table. Observations in the resident's room on 3/28/2023 at 9:30 AM, revealed Resident #9 lying in bed, awake and alert. There were no thickened liquids at bedside or in the resident's refrigerator. When asked if she had water or juice to drink, the resident stated, I would love something to drink. Certified Nursing Assistant (CNA) #1 brought the resident's breakfast tray in the room. The CNA stated, She gets thickened liquids. I guess the nurse gives her water. She don't have a water pitcher . (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/28/2023 at 9:34 AM, when asked if water or other liquids are offered to Resident #9, CNA #1 stated, I don't know about her water or juice. I don't know who gets her that .I give what is on the meal tray. When asked where she could get thickened liquids for the resident, CNA #1 stated, .I don't know. During an interview on 3/28/2023 at 10:29 AM, when asked if thickened liquids are kept in a resident's room and available for staff to offer to a resident, the Director of Nursing (DON) stated, The kitchen has the thickened liquids .They [staff] can go to the kitchen if a resident asks for water or a juice. They could ask the resident if they need a drink while in the room. I'll have to inservice them on that. 3. Review of the medical record revealed Resident #16 was admitted to the facility on [DATE], with diagnoses of Type 2 Diabetes Mellitus, Cerebrovascular Disease, Dementia, Atrial Fibrillation, Heart Failure, Essential Hypertension, and Psoriasis. Review of the quarterly MDS dated [DATE], revealed a BIMS score of 11 which indicated moderate cognitive impairment. Observations in the resident's room on 3/28/2023 at 8:28 AM, revealed Resident #16 lying in bed leaning to her right side attempting to drink from a carton of milk. A half full pitcher of water was on the nightstand out of reach of the resident. There was no cup provided. When asked if she had water to drink, Resident #16 stated, I want water. It's over there [pointed to nightstand], not over here. 4. Review of the medical record revealed Resident #26 was initially admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses of Type 2 Diabetes Mellitus, Chronic Kidney Disease Stage 2, Sleep Apnea, and Hypothyroidism. Review of the quarterly MDS dated [DATE], revealed a BIMS score of 14 which indicated no cognitive impairment. The resident needed limited to extensive assistance for activities of daily living except for eating. Observations in the resident's room on 3/27/2023 at 2:23 PM, revealed Resident #26 was alert and oriented. There was an empty water pitcher on the overbed table. During an interview on 3/27/2023 at 2:25 PM, when asked if the staff passed ice and fresh water, Resident #26 stated, We don't usually keep cold water. Not all workers will pass ice .Sometimes we don't have it till the next day . 5. Review of the medical record revealed Resident #27 was admitted to the facility on [DATE] with diagnoses of Type 2 Diabetes Mellitus, Traumatic Subdural Hemorrhage, Essential Hypertension, and History of Transient Ischemic Attack. Review of the admission MDS dated [DATE], revealed a BIMS score of 13 which indicated no cognitive impairment. Observations in the resident's room on 3/27/2023 at 2:04 PM, revealed a half full water pitcher with room temperature water. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/27/2023 at 2:04 PM, when asked if the staff passed ice and fresh water, Resident #27 stated, We don't get cold water much. When the ice melts that's it. I don't really want room temp [temperature] water. 6. Review of the medical record revealed Resident #28 was admitted to the facility on [DATE] with diagnoses of Down Syndrome, Type 2 Diabetes Mellitus, Epilepsy, and Essential Hypertension. Observations in the resident's room on 3/27/2023 at 2:58 PM, revealed Resident #28 lying bed awake and alert with confusion. The resident's family was at bedside. When the surveyor entered the room a family member asked for a cup of ice water for the resident. The family member stated, .Usually have to ask for ice or I get it myself when I'm here. What water he has is from the ice that melts when he gets it. The pitcher is for ice, I guess. They [staff] don't fill it with water. When we are here, we get it. 7. Review of the medical record revealed Resident #29 initially admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses of Cerebral Infarction, Atherosclerotic Heart Disease, Vascular Dementia, and Essential Hypertension. Review of the quarterly MDS dated [DATE], revealed a BIMS score of 6 which indicated severe cognitive impairment. He needed staff supervision for activities of daily living except for bathing and dressing he needed extensive assistance. Observations in the resident's room on 3/27/2023 at 2:41 PM, revealed Resident #29 seated in a wheelchair. The resident was alert, answered questions appropriately, and initiated conversation. When asked if the staff provided the care he needed, Resident #28 asked, Can I have some water? Hadn't had any [water] for a while. There was an empty water pitcher on the overbed table with no cup provided. 8. Review of the medical record revealed Resident #30 initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Essential Hypertension, and Heart Failure. Review of the admission MDS dated [DATE], revealed a BIMS score of 12 which indicated no cognitive impairment. Observations in the resident's room on 3/28/2023 at 8:01 AM, revealed Resident #30 was in bed in an upright position. There was a water pitcher on the nightstand half full of room temperature water. When asked if she liked cold water or room temperature water to drink, Resident #30 stated, I like to have cold or cool water. I try to drink enough water. Most days you have to ask for ice if you are going to get any. When the ice melts then I have water, unless I ask for water to be put in with the ice. Observations on the 100 hall on 3/28/2023 at 8:15 AM, revealed a CNA placing ice in water pitchers in resident rooms. The CNA did not add water to the ice or leave a cup of ice water at bedside. 9. During an interview on 3/27/2023 at 2:55 PM, when asked what was the routine for passing ice and water to the residents' rooms, CNA #6 stated, We passed ice this morning. The water is not cold now, I guess. We don't put water in the pitchers, just ice. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/28/2023 at 10:29 AM, when asked what the facility protocol was for passing ice and fresh water, the DON stated, Some residents want room temp water; some want ice water .Lot of variables to consider. The staff should be asking when they are in the room if the resident needs anything. They could ask if they need a drink. I'll have to inservice them on that. Maybe they [staff] don't ask. If a resident is confused they [the resident] may not ask. When asked if the staff offer water or other drinks to dependent residents or those that need staff assistance, the DON stated, They should. I'll have to inservice them on that.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 29706 Based on job description review, interview, and document review, the facility Administration failed to administer the facility in a manner that enabled the facility to use its resources effectively and efficiently to attain the highest practicable wellbeing of residents with Dementia and wandering behaviors. Administration failed to provide appropriate oversight to ensure residents with Dementia and wandering behaviors received care in a safe and supervised environment, failed to ensure the facility conducted accurate resident assessments. The facility Administration failed to be accountable for to the Quality Assurance and Performance Improvement (QAPI) developed by the facility to ensure appropriate actions were implemented after a resident eloped from the facility without staff knowledge and supervision. The Administration's failure to ensure a safe environment placed 1 of 14 sampled residents (Resident #1) in Immediate Jeopardy (IJ) when Resident #1, a severely cognitively impaired, vulnerable resident with Dementia, confusion, and wandering behaviors, eloped from the facility on 1/2/2023 at approximately 1:15 PM, walked across the employee back parking lot and was found near the street. Resident #1 was unsupervised outside the building which resulted in Immediate Jeopardy (IJ) for Resident #1. Immediate Jeopardy (IJ) (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified related to the facility's failure to supervise a severely cognitively impaired resident with Dementia, confusion, and a history of wandering behaviors, which resulted in Resident #1's elopement. The facility's failure placed Resident #1 in Immediate Jeopardy. The Administrator and Director of Nursing (DON) were notified of the Immediate Jeopardy on 3/15/2023 at 2:16 PM in the Conference Room. F-835 was cited at a scope and severity of J. The IJ was effective 1/2/2023 and is ongoing. The findings include: 1. Review of the facility's undated Licensed Nursing Home Administrator job description revealed, .The primary purpose of the Nursing Home Administrator position is to oversee the day-to-day operation of the facility, to assure resident safety and to review organizational performance .Oversee that nursing services, social service programs, activity programs, food service programs and medical services are planned, implemented and evaluated to meet resident needs to maximize resident quality of life and quality of care . Identify, monitor, and ensure that quality indicators and quality improvement programs are utilized to maximize effectiveness in resident care and services .Make routine inspections of the facility to assure that established policies and procedures are being followed .establish an effective accident prevention program . Ensure the integration of resident rights with all aspects of the facility environment . (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's undated Director of Nursing Services (DON) job description revealed, .The primary purpose of the Director of Nursing position is to plan, organize, develop, and direct the overall operation of the Nursing Department to ensure that the highest degree of quality care is maintained at all times .Develop, implement, and maintain an ongoing quality assurance performance improvement program for the nursing department .Assist the Quality Assurance Performance Improvement Committee in developing and implementing appropriate plans of action to correct identified deficiencies .Review and insure that charting documentation procedures for nursing are met .Assist in the development of preliminary and comprehensive assessments of the nursing needs of each resident. Ensures a written plan of care for each resident is developed that identifies the problems/needs of the resident indicates the care to be given, goals to be accomplished, and which professional service is responsible for each element of care .Ensure that all personnel involved in providing care to the resident are aware of the resident's care plan. Ensure that nursing personnel refer to the resident's care plan prior to administering daily care to the resident. Review nurses' notes to determine if the care plan is being followed . 2. The facility Administration failed to provide oversight that established and implemented policies and procedures to ensure a safe environment for all residents. On 1/2/2023 Resident #1, a cognitively impaired resident, eloped from the facility without staff knowledge or supervision and was found approximately 1000 feet from the facility on a street sidewalk. The facility Administration failed to ensure all wander/elopement assessments were accurate for 14 of 14 (Residents #1, #4, #6, #7, #8, #10, #12, #18, #19, #20, #21, 23, 24, and #25) sampled residents with wandering behaviors. 3. The facility Administration failed to maintain oversight, establish, and implement policies and procedures to ensure an effective QAPI was established to oversee the facility, failed to identify the root cause of concerns identified, and failed to ensure systems and processes were developed and consistently followed by facility staff related to a safe environment. The facility Administration developed an improvement plan dated 1/2/2023 to address Resident #1 ' s elopement incident. The facility Administration failed to ensure all interventions in the plan were implemented and were accurate as follows: The Improvement plan to review new admits' elopement assessments for appropriate interventions was not accurate as evidenced by the inaccurate wander/elopement assessments. The Improvement plan to audit all elopement assessments was not implemented as the facility was unable to provide the audits, audit results and the assessments that were conducted were not accurate. The Improvement plan to submit all audit results to the QAPI committee to be reviewed and address as needed was not completed. The facility was unable to provide evidence that the QAPI committee received and reviewed the plan and had not had a meeting. During an interview on 3/7/2023 at 2:30 PM, the DON revealed, .As part of our Performance Improvement [PIP] we audited all residents for wandering risk screen/assessments on 1/3 and 1/4 [2023] to see if anyone was at risk for wandering or elopement or if anyone new . When the DON was asked what they learned and about the outcome, he stated .Well I don't know .We did the audit .No, I don't have any quantitative data to show . When asked how you would know your outcome and if you needed to work on something, he stated, . We wouldn't know .We didn't evaluate it or look at the results . (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. During an interview on 3/7/2023 at 9:09 AM, the DON was asked what he did and his role concerning Resident #1's elopement. The DON stated the staff called and told him that Resident #1 was missing from the facility. The DON stated, .I told them to check the parking lot and the basement. I texted the Administrator .I did not come in until the next day .Once he was found I told them to put a wander guard on him and take him upstairs to the secure unit . The DON stated he was not aware of the resident's wandering history based on the information sent from the hospital. The DON stated he did not participate in a Root Cause Analysis (RCA) related to the elopement incident of Resident #1. The DON stated he did not interview all staff involved related to the elopement incident, only Certified Nursing Assistant (CNA) #1 that saw the resident outside and Registered Nurse (RN) #2 that was the Unit Manager for the hall that Resident #1 resided on. During an interview on 3/7/2023 at 2:50 PM the DON was asked about the Performance Improvement Plan (PIP) interventions that included the Audit Elopement Assessments data related to Resident #1's elopement. The DON stated Review new admits elopement assessment and transfer to secure unit for 7-day monitoring if triggered . The DON stated, .I don't have a tool .I don't have results . When asked if there was documentation of an audit with quantitative results, analysis, interventions, evaluation and follow up, The DON stated, .No . The DON was asked did nursing implement anything because of this elopement to keep it from happening again to residents with wandering behaviors. He stated, .No . During an interview on 3/7/2023 at 3:20 PM, CNA #3 revealed, .I work three to eleven and I was here at 3:00 PM. I saw him [Resident #1] standing at the double door in the lobby between 100 hall and the lobby. He said I am trying to go to [Name of a street]. I said OK well, let me go down here and see what is going on. I came back up front and he was gone . During an interview on 3/15/2023 at 1:00 PM the Administrator was asked what had been put in place since the elopement that will prevent it from happening again. The Administrator stated, .We fixed the gate and the courtyard fence . When the surveyor reviewed the inaccurate wander risk screen assessments with the Administrator, the Administrator stated, .That has definitely got to be fixed . The Administrator was asked about discrepancies with the wander guard system, the ineffective the interventions of checking the functionality of the wander guards, not following or obtaining a physician's order for the wander guards, staff being unaware of the policies/interventions for wander guards, and the non-secure exit doors on the 3/15/2023 tour, The Administrator stated .Yeah .Yes .that has to be fixed . Refer to F689 and F867.

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 29706 Based on job description review, policy review, document review, and interview, the Quality Assurance Performance Improvement (QAPI) committee failed to provide oversight that established and implemented policies and procedures to assure the facility was administered in a manner to use its resources effectively and efficiently. The QAPI committee failed to ensure a QAPI program that identified opportunities for improvement related to accurate wandering/elopement assessments and failed to implement performance improvement activities to provide a safe environment for residents, identify, report, investigate and prevent incidents of elopement and failed to ensure systemic processes were in place and consistently followed by staff and administration. The QAPI committee failed to implement a systematic approach to accurately identify and assess, implement interventions, monitor the implementation of and the effectiveness of its performance improvement activities to ensure improvements are sustained in identifying processes to identify deviations and adverse events when a resident exited the facility without staff knowledge, failed to provide adequate supervision to prevent elopement and failed to ensure a safe environment for 1 of 14 sampled residents (Resident #1) in Immediate Jeopardy when Resident #1, a severely cognitively impaired, vulnerable resident with Dementia, confusion, and wandering behaviors, eloped from the on 1/2/2023 at an unknown time after 1:15 PM, walked across the employee back parking lot and was found near the street. Resident #1 was unsupervised outside the building which resulted in Immediate Jeopardy (IJ) for Resident #1. Immediate Jeopardy (IJ) (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified related to the facility's failure to supervise a severely cognitively impaired resident with Dementia, confusion, and a history of wandering behaviors, which resulted in Resident #1's elopement. The facility's failure placed Resident #1 in Immediate Jeopardy. The Administrator and Director of Nursing (DON) were notified of the Immediate Jeopardy on 3/15/2023 at 2:16 PM in the Conference Room. F-867 was cited at a scope and severity of J. The IJ was effective 1/2/2023 and is ongoing. The findings include: (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Review of the facility's undated Quality Assurance and Performance Improvement [QAPI] Policy and Procedure, revealed .To ensure that [Name of the facility] implements a comprehensive QAPI program which addresses all the care and unique services that the Facility provides. To ensure continuous evaluation of the Facility's systems .It is the policy of the Facility to develop, implement, and maintain an effective, comprehensive, data driven QAPI program that focuses on indicators of the outcomes of care and quality of life .The facility will maintain a QAPI program that will ensure that the Facility obtains feedback, uses data, and takes action to conduct structured, systematic investigations and analysis of underlying causes or contributing factors of problems affecting Facility-wide processes that impacts quality of care, quality of life, and resident safety .The facility shall develop and implement policies and procedures .These approaches may include root cause analysis, reverse tracker methodology, or healthcare failure and effects analysis .The Facility shall collect and monitor data reflecting its performance, including adverse events. Data collection can be done by audit tools, direct observations, interview, or testing .The Facility will take actions aimed at performance improvement, which includes implementation of corrective actions, measuring success, and tracking performance, to ensure improvements are achieved and sustained .The performance improvement activities will track medical errors and adverse resident events, analyze their causes, implement preventive actions and mechanisms to prevent future events .Responsibilities of QAA [Quality Assurance] Committee .is responsible for .Regularly reviewing and analyzing data .acting on available data to make improvements; identifying and responding to quality deficiencies throughout the facility; .developing and implementing corrective action, and monitoring to ensure performance goals or targets are achieved; revising corrective action when necessary . Review of the facility's policy Quality Assurance Performance Improvement dated 12/15/2020 and reviewed 12/15/2022, revealed .The facility shall implement a QAPI program that addresses all the care and unique services the facility provides .The Administration of this facility will develop and lead the QAPI program .This facility will implement and maintain systems to monitor care and services, drawing data from multiple sources .It also includes tracking, investigating, and monitoring Adverse Events that will be investigated every time they occur, and action plans implemented to prevent recurrences .This facility will conduct Performance Improvements Projects [PIPs] to examine and improve care or services in areas that are identified as needing attention .This facility will use a systematic approach to determine when in-depth analysis is needed to fully understand the problem, its root causes, and implications of a change .This facility has policies and procedures to demonstrate proficiency in the use of Root Cause Analysis . 2. Review of the facility's undated Licensed Nursing Home Administrator job description revealed, .The primary purpose of the Nursing Home Administrator position is to oversee the day-to-day operation of the facility, to assure resident safety and to review organizational performance .Oversee that nursing services, social service programs, activity programs, food service programs and medical services are planned, implemented and evaluated to meet resident needs to maximize resident quality of life and quality of care . Identify, monitor, and ensure that quality indicators and quality improvement programs are utilized to maximize effectiveness in resident care and services .Make routine inspections of the facility to assure that established policies and procedures are being followed .establish an effective accident prevention program . Ensure the integration of resident rights with all aspects of the facility environment . (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 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's undated Director of Nursing Services (DON) job description revealed, .The primary purpose of the Director of Nursing position is to plan, organize, develop, and direct the overall operation of the Nursing Department to ensure that the highest degree of quality care is maintained at all times .Develop, implement, and maintain an ongoing quality assurance performance improvement program for the nursing department .Assist the Quality Assurance Performance Improvement Committee in developing and implementing appropriate plans of action to correct identified deficiencies .Review and insure that charting documentation procedures for nursing are met .Assist in the development of preliminary and comprehensive assessments of the nursing needs of each resident. Ensures a written plan of care for each resident is developed that identifies the problems/needs of the resident indicates the care to be given, goals to be accomplished, and which professional service is responsible for each element of care .Ensure that all personnel involved in providing care to the resident are aware of the resident's care plan. Ensure that nursing personnel refer to the resident's care plan prior to administering daily care to the resident. Review nurses' notes to determine if the care plan is being followed . 3. Resident #1 was admitted to the facility from the hospital on 12/30/2022. The hospital's History and physical was sent to the facility upon the resident's admission and revealed Resident #1 had lived with his nephew, had falls at home, and was having more confusion with periods of sundowning and wandering at night. A staff interview revealed that cognitively impaired Resident #1 exhibited exit seeking behaviors prior to exiting/eloping from the facility. On 1/2/2023 on the 3:00 PM -11:00 PM shift, Certified Nursing Assistant (CNA) #3 stated, .I saw him [Resident #1] standing at the double door in the lobby between 100 hall and the lobby. He said I am trying to go to [Name of a street]. I said ok well, let me go down here and see what is going on. I came back up front and he was gone . There were no interventions implemented for Resident #1's exit seeking behaviors at that time. Resident #1 exited/eloped on 1/2/2023 at an unknown time and was out of the facility unknown to staff and unsupervised by staff for an unknown period of time. The resident was later found by Registered Nurse (RN) #2. RN #2 stated, . I can't remember what time I found him on the far side of the back employee parking lot located near the street [Name of the street] and the apartments .He was walking and looking left and right like didn't know where to go, not sure .Just me and him I don't remember any other staff around when I found him. He had on pants and a shirt .It was a little rainy, wet but not cold .I called his name and he said Hey baby I'm glad to see you . The facility's investigation dated 1/3/2023 of Resident #1's elopement on 1/2/2023 revealed he was found outside on the sidewalk beside the street, a 1,000 feet from the building. The facility documented Resident #1 exited the courtyard either thru a gap between a chain link fence and gate (that was loosely locked with a bike type rope lock) or through a gap that was between the chain link fence and the building wall. The facility failed to save the video as part of the investigation and did not include a summary of the video with times and locations in the investigation. The surveyor was unable to view the video and the Administrator did not keep notes from review of the video. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. The facility Administration failed to maintain oversight, establish, and implement policies and procedures to ensure an effective QAPI was established to oversee the facility, failed to identify the root cause of concerns identified, and failed to ensure systems and processes were developed and consistently followed by facility staff related to a safe environment. Review of facility data and information obtained during the survey revealed the QAPI committee members consist of at the Administrator, DON, Minimum Data Set (MDS) Nurse, Social Services, Medical Director, Medical Director designee, and Consultant. The facility developed an improvement plan dated 1/2/2023 to address Resident #1's elopement incident. The facility failed to ensure the following interventions were implemented: The Improvement plan to review new admits' elopement assessments for appropriate interventions failed to be implemented as evidenced by the wander/elopement assessments not containing all data. The Improvement plan to audit all elopement assessments was not implemented as the facility was unable to provide the audits, audit results and the assessments that were conducted were not accurate. The Improvement plan to submit all audit results to the QAPI committee to be reviewed and address as needed was not completed as the facility could not provide evidence. The facility's QAPI committee failed to ensure the facility developed, implemented, monitored and sustained appropriate actions to prevent resident elopements and failed to ensure policies and procedures were followed in accordance with the facility QAPI policy. 5. During an interview on 3/7/2023 at 2:30 PM, the DON revealed, .As part of our Performance Improvement [PIP] we audited all residents for wandering risk screen/assessments on 1/3 and 1/4 [2023] to see if anyone was at risk for wandering or elopement or if anyone new . When the DON was asked what was learned and what the outcome was, he stated .Well I don't know .We did the audit .No, I don't have any quantitative data to show . When asked how you would know your outcome and if you needed to work on something, he stated, .We wouldn't know .We didn't evaluate it or look at the results . When asked did you do 100% of the residents, he stated .Yes . When asked about QAPI and the elopement discussion he stated, .I just get into the clinical side how everyone was .didn't get involved in investigation or how he got out. That was administrator and maintenance director . The Surveyor requested every day during the survey for the DON to provide the Performance Improvement Project (PIP) results of an audit of all new admits elopement assessment after 1/4/2023. The DON did not provide documentation of the audit or results during the survey. Review of the facility's census on 1/3/2023, revealed 131 residents. Review of the list of residents with a wander risk screen provided by the DON revealed 48 out of 131 were not completed for a 36.6%. When the DON was asked did you do quantitative results he stated .No .we didn't do that . When asked why were only 63.4% completed, He stated, .I didn't know all [resident screens] were not done .two of my unit managers were to do them . When asked what the analysis and interventions put into place, and were the interventions monitored and evaluated, he stated .We didn't do any of that . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445150	A. Building B. Wing	03/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Gardens at Memphis Rehab & Snc	131 N Tucker Memphis, TN 38104

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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 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 3/6/2023 at 12:53 PM, RN #2 was asked what interventions were implemented after the elopement. She stated, .everything stayed the same .I [RN #2] have no knowledge of anything implemented since . When she was asked were you part of a QAPI meeting to discuss the elopement and part of a root cause analysis, she stated, .I was not part of a root cause analysis or QAPI meeting .yes that is my signature on the QAPI paper, but I was not part of a meeting .nothing was implemented that I am aware of . During an interview on 3/15/2023 at 1:00 PM, RN #2 was asked did you participate in the wander risk screen audit for all residents, she stated .I just did what I was told .I did 100 hall .I don't recall anything we did in response to the audit .my process is the same I don't do anything different .it's the same . When she was asked did you audit all residents on 100 hall, she stated .I guess I missed some . During an interview on 3/6/2023 at 2:32 PM, the Director of Maintenance revealed .I don't go to QAPI .I am not part of the QAPI meeting . During an interview on 3/7/2023 at 7:50 AM, RN #1 was asked about her role in QAPI, she stated .Yes that is my signature [QAPI signature sheet] but I can't remember anything about it [meeting about elopement 1/2/2023] .No, don't know how he got out or what interventions put in place after that .I don't know anything about any root cause analysis or analysis . During an interview on 3/8/2023 at 12:30 PM, the Nurse Practitioner revealed, .I got a call when he [Resident #1] got out .I came in the next day examined [named person Resident #1] and met with administrator and I can't remember who else was in there in [named DON] office .I was told he got out through the basement door .I don't know who said that . When asked if she received any follow up from the 1/3/2023 meeting, she stated, .No, I have received no follow up .No discussion .He got out through the basement as far as I know . During an interview on 3/14/2023 at 3:16 PM, the Administrator was asked if a root cause analysis was performed. He stated, .I thought my PIP was a root cause analysis .No, I didn't include in the analysis people involved .If something is nursing, I let [named person DON] speak to that .I watched the video and concluded how he got out . When the Administrator was asked did you ask the staff about any behaviors or triggers the resident may have experienced prior to the incident, the Administrator stated, .I didn't think about that .No, I didn't include direct care staff . When the Administrator was asked did you follow up, what did you do with the audit results or learn from the audit, he stated .No, I see what you are saying . During an interview on 3/15/2023 at 1:00 PM, the Administrator was asked about the Quality Assessment & Performance Improvement (QAPI) PIP dated 1/2/2023, the audit results of all residents wander risk screen/assessments dated 1/3/2023 and 1/4/2023 and the audit results of all new admits after 1/4/2023 wandering risk screen/elopement assessments. He stated, .If it's not there, it is not there .No proof it [audit, analysis, interventions, follow up] was done .I understand not done . Refer to F 689 and F835.