STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445331	A. Building B. Wing	08/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Graceland Rehabilitation and Nursing Care Center	1250 Farrow Road Memphis, TN 38116

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35806 Based on policy review, Board of Examiners of Nursing Home Administrators (BENHA) review, medical record review, observation, and interview, the facility failed to provide adequate supervision to prevent neglect of a vulnerable and confused resident for 1 of 6 sampled residents (Resident #1) reviewed for wandering/elopement behaviors, when Resident #1 eloped without staff awareness on a hot July day through an unlocked exit door on the 300 Hall, walked outside the facility, walked down the sidewalk and into the back parking lot, traveling approximately 63 feet from the facility. Resident #1 was unsupervised and without staff awareness for approximately 35 minutes. Immediate Jeopardy (IJ) is 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. The Administrator and the Director of Nursing (DON) were notified of the Immediate Jeopardy on 8/26/2021 at 3:16 PM, in the Conference Room. The facility was cited Immediate Jeopardy at F-600. The facility was cited at F-600 at a scope and severity of J, which is Substandard Quality of Care. The Immediate Jeopardy was effective from 7/2/2021 through 8/29/2021. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on 8/28/2021 at 5:38 PM, and was validated onsite by the surveyors on 8/29/2021 and 8/30/2021 through observations, review of audits, meeting minutes, and staff interviews. The findings include: Review of the facility's undated policy titled, .ABUSE PREVENTION, revealed .Neglect: A failure of the facility, it's employees, or services provided .to provide goods and services necessary to avoid physical harm, mental anguish, emotional distress, or pain .It is the responsibility of all staff to provide a safe environment for the residents. Resident care and treatments shall be monitored by all staff, on an ongoing basis, so that residents are free from abuse, neglect, or mistreatment . (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's undated policy titled, MISSING RESIDENT/ELOPEMENTS, revealed .The Unit Charge Nurse is responsible for knowing the location of their residents .Missing Resident Guidelines . Determine time and location when last seen . Review of the facility's policy titled, Wandering, Unsafe Resident, revised 8/2014, revealed .The facility will strive to prevent unsafe wandering .The staff will identify residents who are at risk for harm because of unsafe wandering (including elopement) .The staff will assess at-risk individuals for potentially correctable risk factors related to unsafe wandering .A missing resident is considered a facility-wide emergency . Review of the facility's undated policy titled, CLINICAL SERVICES Subject: Wander Guard [a bracelet device that will trigger the door to alarm when the resident gets too close to the door]/Secure Care Alarm, revealed . Residents that have been identified as an elopement risk will have a wander guard/secure care device applied to ensure their safety . Review of the BENHA form revealed the Administrator had an employment date of 7/6/2020. Review of the medical record, revealed Resident #1 was admitted to the facility on [DATE] with diagnoses of Dementia, Cerebral Infarction, Hemiplegia, and Hemiparesis. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 had moderately impaired cognition for decision making and required staff supervision when walking in her room or in the corridor. Review of a Progress Note dated 6/27/2021 at 1:38 PM, revealed .Wandering resident redirected to the 200 hall where her room was located twice before she wandered out of the exit at the end of the 300 hall. She was returned to the inside of the building before the exit door closed behind her . Review of a Progress Note dated 6/27/2021 at 3:13 PM, revealed .Resident [Resident #1] walking away from 200 hall continued to redirect her back to 200 hall Resident stated .'going home' . Review of the Care Plan dated 7/2/2021, revealed Resident #1 was at risk for elopement and wandering, had a communication deficit, and a diagnosis of Dementia. Review of an Incident Audit Report dated 7/2/2021, revealed .Resident seen outside by therapy assistance [assistant]. Per therapist .As I was exiting the parking lot, I notice [noticed] a resident walking down the walkway .I immediately parked my vehicle and called my direct supervisor to inform her of what was taking place .Resident Description .I am trying to go over [to] my daughter [daughter's] house .I don't want to be here . Review of the vital signs report revealed the only vital sign documented on 7/2/2021 was a temperature reading of 97.3 at 7:22 PM, approximately 3 hours after Resident #1 was returned to the facility from the parking lot. Review of a Physician's Order dated 7/3/2021, revealed Resident #1 had an order for a wander guard. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 8/23/2021 at 2:15 PM, the Rehabilitation Director confirmed she saw Resident #1 in the parking lot with the Speech Language Pathologist. She stated, .I walked her to her room. She was tired, that distance from her room to outside was enough to get her fatigued .I went and told [Named Unit Manager] .she didn't know that she was out of the building . During an interview on 8/23/2021 at 2:31 PM, the DON confirmed she had reviewed video footage of Resident #1's elopement. The DON confirmed she had not saved the recorded video footage of the elopement and confirmed she did not do a timeline of the incident based on the time stamps on the video footage. Observation in the parking lot on 8/23/2021 at 4:45 PM, revealed the Speech Language Pathologist identified the area where Resident #1 was located after her elopement. The Rehabilitation Director placed red duct tape on the pavement in the middle of the parking lot to mark where Resident #1 was found. Observation in the parking lot on 8/24/2021 at 8:30 AM, the Physical Therapy Assistant measured the distance from the 300 Hall Exit Door to the area where Resident #1 was found after she eloped. The distance was approximately 63 feet. Observation in the resident's room on 8/24/2021 at 12:15 PM, 8/25/2021 at 2:45 PM, and 8/26/2021 at 10:30 AM, revealed Resident #1 had a wander guard attached to her right ankle with an elastic string from a face mask. During a telephone interview on 8/24/2021 at 2:20 PM, Licensed Practical Nurse (LPN) #1 was asked when she last saw Resident #1 on the afternoon of 7/2/2021. LPN #1 stated, .around 3:45 PM, was in room with her doing her sugar [blood glucose check] .next thing I know, they reported she was found in the parking lot . She stated, .it was hot out . During an interview on 8/25/2021 at 11:24 AM, the Administrator stated, .we have been working on the doors .from time to time one of those doors would malfunction with ya'll here, we identified the Service Hall Door .If the lock don't secure all the way, it might make the door not close .At times the door may not latch .It's an ongoing process, we've gotten several quotes .it's very expensive . During an interview on 8/26/2021 at 9:55 AM, the Maintenance Director confirmed the 800 Hall Dining Room Exit Door was also broken and a padlock with a combination was kept on the door because it was under construction. The Maintenance Director was asked about the 300 Hall Exit Door. He stated, .We had to fix it temporarily. When you came in, we determined it would not release in the 15 seconds, so we called [Named Alarm System Company] . During an interview on 8/26/2021 at 1:06 PM, the Unit Manager was asked about Resident #1's wander guard, she stated she could not find a wander guard strap and used an elastic string from a face mask to tie the wander guard receiver around Resident #1's ankle. The Unit Manager also stated, .I didn't tell anyone to go check the doors [after the elopement incident] . During a telephone interview on 8/27/2021 at 12:05 PM, Certified Nursing Assistant (CNA) #1 confirmed she worked the evening shift on 7/2/2021 when Resident #1 eloped. She was asked when she last saw Resident #1 before she eloped. She stated, .I don't remember .she was always walking around in the halls . (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 8/28/2021 at 10:29 AM, CNA #2 was asked when she last saw Resident #1 on the afternoon of 7/2/2021, the day she eloped. CNA #2 stated, .It was about 3:30 [PM]. That's the last time I saw her before they brought her back. During an interview on 8/29/2021 at 11:35 AM, LPN #2 confirmed that Resident #1's wander guard receiver was not attached correctly. She stated, .I don't know why it has that string, it's supposed to have a wander guard strap . During an interview on 8/30/2021 at 12:15 PM, the Unit Manager confirmed the only vital sign that was checked after Resident #1 eloped was a temperature, and that was done at 7:22 PM. She confirmed a complete set of vital signs were not documented as part of the full head-to-toe assessment after Resident #1 eloped. The facility neglected to supervise and maintain safety for Resident #1, a cognitively impaired resident with wandering and exit seeking behaviors, which resulted in the resident exiting the facility unsupervised. Refer to F-689, F-609, F-610, F-726, F-725, F-835 and F-867. The surveyors verified the Removal Plan by: 1. On 7/3/2021, Resident #1 was reassessed for elopement risk and was found to be at risk for elopement. Resident #1's Care Plan was updated to reflect elopement and a wander guard was placed on Resident #1 for safety. The surveyors reviewed the Elopement Assessment and Care Plan. 2. On 8/23/2021, all residents were assessed for elopement and no new resident was identified. The surveyors reviewed the Elopement Assessments. 3. On 7/2/2021, the door Resident #1 exited was found not to be latching and the door was immediately repaired. The surveyors checked the doors. 4. Starting 8/27/2021, all exit doors will be checked every 30 minutes for the next two weeks, and then will return to daily checks to ensure they are functioning properly. If doors are found not to be functioning properly, the Administrator and/or the DON will be notified, and someone will be assigned to monitor the doors until they are functioning properly. The surveyors reviewed the Door Check sheets to confirm the 30-minute checks were done. 5. On 8/29/2021 through 8/30/2021 staff were in-serviced on abuse, neglect, wandering residents, residents with exit seeking behaviors, and those identified for elopement. The surveyors reviewed the in-services and interviewed staff on all shifts. 6. On 8/26/2021, the Elopement Assessment Tool has been reviewed by the DON and the use of the tool will be in-serviced to all licensed nurses by 9/7/2021. The surveyors reviewed the Elopement Assessment Tool and interviewed nurses on all shifts. 7. On 8/29/2021 through 8/30/2021, staff received education on how to accurately complete the Elopement Risk Assessment. The surveyors reviewed the in-services and interviewed staff on all shifts. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8. On 8/29/2021 through 8/30/2021, the staff were in-serviced on door alarm sounds, and if the exit door alarm was activated, they are to go outside, search the grounds and staff inside the building will ensure all residents are in the facility. The surveyors reviewed the in-services and interviewed staff on all shifts. 9. The DON will review all new admissions and readmissions the next working day for elopement assessments to ensure timeliness and accuracy. If a resident is determined to be at elopement risk, the Care Plan will be implemented, and a wander guard will be placed on the resident. The surveyors reviewed the DON audits and interviewed the DON. 10. Any employee who is out on leave will be in-serviced prior to starting work. The facility's noncompliance at F-600 continues at a scope and severity of D for monitoring the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction.

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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35806 Based on policy review, medical record review, observation, and interview, the facility failed to report incidents of elopement for 1 of 6 sampled residents (Resident #1) reviewed for wandering and elopement. The facility's failure to report an incident of elopement and neglect to the State Survey Agency resulted in Immediate Jeopardy when Resident #1 eloped through an unlocked exit door on the 300 Hall, walked outside the facility unsupervised, down the sidewalk, and into the back parking lot on a hot July day. The distance the resident traveled was approximately 63 feet from the facility. Resident #1, a confused and vulnerable resident, was unsupervised and without staff awareness for approximately 35 minutes. Immediate Jeopardy (IJ) is 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. The Administrator and the Director of Nursing (DON) were notified of the Immediate Jeopardy on 8/26/2021 at 3:16 PM, in the Conference Room. The facility was cited Immediate Jeopardy at F-609. The facility was cited at F-609 at a scope and severity of J, which is Substandard Quality of Care. The Immediate Jeopardy was effective from 7/2/2021 through 8/29/2021. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on 8/28/2021 at 5:38 PM, and was validated onsite by the surveyors on 8/29/2021 and 8/30/2021 through observations, review of audits, meeting minutes, and staff interviews. The findings include: Review of the facility's undated policy titled, .ABUSE PREVENTION, revealed .Alleged violations involving abuse, neglect, exploitation or mistreatment, including injury of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury .to other officials .including State Survey Agency .Report the results of all investigations to the administrator or designated representative and other officials in accordance with state law including State Survey Agency within 5 working days of the incident . Review of the medical record, revealed Resident #1 was admitted to the facility on [DATE] with diagnoses of Dementia, Cerebral Infarction, Hemiplegia, and Hemiparesis. (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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 had moderately impaired cognition for decision making and required staff supervision when walking in her room or in the corridor. Review of an Incident Audit Report dated 7/2/2021, revealed .Resident seen outside by therapy assistance [assistant]. Per therapist .As I was exiting the parking lot, I notice [noticed] a resident walking down the walkway .I immediately parked my vehicle and called my direct supervisor to inform her of what was taking place .Resident Description .I am trying to go over my daughter [daughter's] house .I don't want to be here . Review of an undated Speech Language Pathologist Witness Statement, revealed the Speech Language Pathologist documented leaving the facility on 7/2/2021 at approximately 4:25 PM and observed a resident ambulating down the walkway into the parking lot. The Speech Language Pathologist notified her supervisor and facility employees came to assist the resident. Observation in the facility parking lot on 8/23/2021 at 4:45 PM, revealed the Speech Language Pathologist identified the location in the center of the parking lot where Resident #1 was found. On 8/24/2021 at 8:30 AM, the Physical Therapy Assistant measured the distance from the 300 Hall Exit Door to the marked area where Resident #1 was found after she eloped. The distance measured was approximately 63 feet. During an interview on 8/23/2021 at 12:30 PM, the Director of Nursing (DON) confirmed the facility had not reported the elopement and stated, .I didn't know we had to . During an interview on 8/24/2021 at 5:30 PM, the Administrator stated, .I didn't know the regulation changed. I hadn't read the regulations . During an interview on 8/24/2021 at 5:35 PM, the DON stated, .I didn't know the change in the regs [regulations] where it .elopement is moving from a safe place to an unsafe place .I went by 2016 regs . During an interview on 8/25/2021 at 11:40 AM, the DON stated, .I don't read the regs .I'm being honest with you . During an interview on 8/25/2021 at 11:45 AM, the Administrator stated, .I didn't know the regs said potential. I thought the verbiage said likely. I didn't read the regs .I read it after the [Named Surveyor] told us about it . Refer to F-600, F-610, and F-689. The surveyors verified the removal plan by: 1.The facility will report going forward any resident noted outside without proper supervision or being unattended. The Director of Nursing and/or the Administrator will report elopement to the state agency to include Adult Protective Services within 24 hours if no injuries occur, or 2 hours if serious injuries occur. The surveyors interviewed the Administrator and the DON. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. On 8/29/2021 through 8/30/2021, staff were in-serviced on abuse, neglect, reporting requirements, wandering residents, residents exit seeking, and those identified for elopement. The surveyors reviewed the in-services and interviewed staff on all shifts. 3. The DON will review all new admissions and readmissions the next working day for elopement assessments to ensure timeliness and accuracy. If a resident is determined to be at elopement risk, the Care Plan will be implemented, and a wander guard will be placed on the resident. The surveyors reviewed the DON audits and interviewed the DON. 4. Starting 8/27/2021, all exit doors will be checked every 30 minutes for the next two weeks, and then will return to daily checks to ensure they are functioning properly. If doors are found not to be functioning properly, the Administrator and/or the DON will be notified, and someone will be assigned to monitor the doors until they are functioning properly. The surveyors reviewed the Door Check sheets to confirm the 30-minute checks were done. 5. On 8/29/2021 through 8/30/2021, the staff were in-serviced on door alarm sounds, and if the exit door has been activated, they are to go outside and search the grounds and staff inside the building will ensure all residents are accounted for. The surveyors reviewed the in-services and interviewed staff on all shifts. 6. The facility will utilize a Corporate Compliance Company monthly to review incident and accidents as oversight. The surveyors interviewed the Corporate Compliance Officer. 7. Any employee who is out on leave will be in-serviced prior to starting work. The facility's noncompliance at F-609 continues at a scope and severity of D for the monitoring the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction.

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35806 Based on policy review, medical record review, observation, and interview, the facility failed to thoroughly investigate an incident of elopement for 1 of 6 sampled residents (Resident #1) reviewed for elopement and wandering. The facility's failure to thoroughly investigate an incident of elopement resulted in Immediate Jeopardy when Resident #1 eloped through an unlocked exit door on the 300 Hall on a hot July day, walked outside the facility unsupervised, walked down the sidewalk, and into the back parking lot. The vulnerable, confused resident ambulated approximately 63 feet from the facility and was unsupervised for approximately 35 minutes. Immediate Jeopardy (IJ) is 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. The Administrator and the Director of Nursing (DON) were notified of the Immediate Jeopardy on 8/26/2021 at 3:16 PM, in the Conference Room. The facility was cited Immediate Jeopardy at F-610. The facility was cited Immediate Jeopardy at F-610 at a scope and severity of J, which is Substandard Quality of Care. The Immediate Jeopardy was effective from 7/2/2021 through 8/29/2021. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on 8/28/2021 at 5:38 PM, and was validated onsite by the surveyors 8/29/2021 and 8/30/2021 through policy review, medical record review, observation, education in-service records review, and staff interviews. The findings include: Review of the facility's policy titled, Accidents and Incidents-Investigating and Reporting, revised 7/2017, revealed .All accidents or incidents involving residents .occurring on our premises shall be investigated and reported to the Administrator .The Nursing Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of accident or incident .The following data .shall be included .The circumstances surrounding the accident or incident .The name(s) of witnesses and their accounts of the accident or incident .The condition of the injured person, including his/her vital signs . Follow-up information .Other pertinent data .The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall complete a Report of Incident/Accident form and submit the original to the Director of Nursing Services within 24 hours of the incident or accident . Review of the facility's undated policy titled, .ABUSE PREVENTION, revealed .The facility will initiate at the time of any finding of potential abuse or neglect an investigation to determine cause and effect, and provide protection to any alleged victims to prevent harm during the continuance of the investigation . (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the medical record, revealed Resident #1 was admitted to the facility on [DATE] with diagnoses of Dementia, Cerebral Infarction, Hemiplegia, and Hemiparesis. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 had moderately impaired cognition for decision making and required staff supervision when walking in her room or in the corridor. The facility's investigation provided to the surveyors on 8/23/2021 at 12:05 PM, included: a. An Incident Audit Report dated 7/2/2021, revealed .Resident seen outside by therapy assistance [assistant]. Per therapist .As I was exiting the parking lot, I notice [noticed] a resident walking down the walkway .I immediately parked my vehicle and called my direct supervisor to inform her of what was taking place .Resident Description .I am trying to go over my daughter [daughter's] house .I don't want to be here . b. 1 undated handwritten statement by the Speech Language Pathologist, revealed .On Friday, July 2nd, at approximately 4:25p [4:25 PM], I was leaving the building for the day. As I was exiting the parking lot, I notice [noticed] a resident walking down the walkway. I did not witness the resident exiting the building. I immediately parked my vehicle .called my direct supervisor to inform her of what was taking place. I made contact with the resident .asked if she was okay. Resident replied 'I am looking for my truck' My direct supervisor .and the secretary on [Named Hall] [300 Hall] immediately came out to assist . c. An Elopement assessment dated [DATE], revealed .Immediate Action Taken .Assessed resident thoughts as to what she was trying to do. Notified DNP [Doctor of Nursing Practice], Psych [Psychologist], and RR [Responsible Party]. Elopement/Wandering monitoring report in place, Elopement Risk assessment completed. SBAR [Situation-Background-Assessment-Recommendation-a communication model to facilitate prompt and organized flow of information] completed. Care Plan updated, and Incident place [placed] on 24hr [24 hour] report . d. An SBAR - Physician Communication Tool dated 7/2/2021, revealed .Exited facility through 300 hall exit door .Vitals .Temperature .98.3 Date [obtained] .7/2/2021 at 09:47 AM .Pulse .87 . e. Physician's Orders dated 7/3/2021, revealed .Wanderguard [a bracelet device that will trigger the door to alarm when the resident gets too close to the door] to right ankle . The facility's investigation of the elopement of Resident #1 on 7/2/2021 did not include interviews/statements from other staff working on the day of the elopement, did not include interviews/statements from staff working on previous shifts, did not include a full assessment of the resident after the elopement, did not include elopement or skin assessments of other residents, and did not include checking all the doors to be assured they could not be opened by the residents, and did not include interviews with the maintenance department staff regarding the security of the doors. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Graceland Rehabilitation and Nursing Care Center	1250 Farrow Road Memphis, TN 38116

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 8/23/2021 at 2:15 PM, the Rehabilitation Director stated the Speech Language Pathologist called her and stated Resident #1 was in the parking lot. The Rehabilitation Director proceeded to the parking lot with the secretary from 300 Hall to bring the resident back into the facility. They assisted the resident back into the facility and to her room. The Unit Manager was unaware the resident was not in the facility until was told by the Rehabilitation Director that the resident was back in her room. The Rehabilitation Director was asked if the facility asked her to write a statement of this event as part of the investigation. She stated, No. During an interview on 8/23/2021 at 2:31 PM, the Director of Nursing (DON) confirmed she watched video camera footage of Resident #1 exiting the building. She was asked if she had a copy of the video footage. She stated, .If they don't get off the premises, it's not an elopement .I didn't keep the video . During an interview on 8/23/2021 at 4:30 PM, the 300 Hall Secretary stated she kept hearing the door alarm and when she arrived at the door that was alarming a staff member from therapy stated Resident #1 was in the parking lot. There was no witness statement by the 300 Hall Secretary in the investigation provided by the facility of Resident #1's elopement on 7/2/2021. During an interview on 8/24/2021 at 10:47 AM, Maintenance Assistant #1 stated, .they called me and said a lady got out and we came up here and found that the door [300 Hall Exit Door] wasn't locking .When we got here, we went straight to the [300 Hall Exit Door] and it opened right up when we pushed it .Something was wrong with the keypad . There was no witness statement by Maintenance Assistant #1 in the investigation provided by the facility of Resident #1's elopement on 7/2/2021. During a telephone interview on 8/24/2021 at 2:20 PM, Licensed Practical Nurse (LPN) #1 confirmed she was the nurse on duty the evening Resident #1 eloped. She obtained a blood glucose test on Resident #1 around 3:45 PM and the resident was in her room at that time. She later became aware that Resident #1 was in the parking lot. She stated, .When they brought her back in, I checked her out .just wanted to make sure she was ok, it was hot out . There was no documentation of a witness statement by LPN #1 regarding the elopement of Resident #1 in the investigation provided by the facility of the resident's elopement on 7/2/2021. Observation in the facility parking lot on 8/23/2021 at 4:45 PM, revealed the Speech Language Pathologist identified the location in the center of the parking lot where Resident #1 was found. On 8/24/2021 at 8:30 AM, the Physical Therapy Assistant measured the distance from the 300 Hall Exit Door to the marked area where Resident #1 was found after she eloped. The distance measured was approximately 63 feet. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 8/25/2021 at 11:24 AM, the Administrator stated, .[Named DON] reviewed the camera and it showed where she went out . She was asked if she had reviewed the video camera footage. She stated, I did not. I did not think about saving it . The Administrator was asked if the DON had written a timeline based on the time stamps on the video camera footage of the elopement. She stated, No . The Administrator stated, .from time to time one of those doors would malfunction . She was asked which doors malfunctioned. She stated, .it could be random, we've had to work on the [Named Hall] [300 Hall] door .with ya'll here, we identified the Service Hall Door .If the lock don't secure all the way, it might make the door not close .At times the door may not latch . The Administrator was asked which doors do not latch. She stated, . I'm not sure .None of them are alarming at the [Nursing] station . The Administrator was asked if the facility had done a thorough investigation of the elopement. She stated, We could have investigated more. We didn't consider it an elopement . During an interview on 8/26/2021 at 9:55 AM, the Maintenance Director was asked about the 300 Hall Exit Door. He stated, .We had to fix it temporarily. When you came in, we determined it would not release in the 15 seconds, so we called [Named Alarm System Company]. [Named Maintenance Assistant #2] was supposed to fix it. They said they fixed it. We worked on that door when [Named Alarm System Company] came out, and they checked all the doors. You can put a Phillip's head screwdriver and go inside the keypad . we are going to put tamper proof screws on the keypads. They found that one box in the whole building had a tamper proof screw. He stated, .You cannot leave a door that is not operating right without somebody watching it . If they [a resident] gets out of this building, it's nothing but trouble. The procedure, we got to watch a door if it's not working. I told [Named DON]. I don't know what's up .something's going on with these doors . There was no documentation of a witness statement by the Maintenance Director regarding the elopement of Resident #1 in the investigation provided by the facility of the resident's elopement on 7/2/2021. During an interview on 8/26/2021 at 1:06 PM, the Unit Manager confirmed Elopement Risk Assessments had not been done on other residents as part of the elopement investigation. She confirmed they had been done on 8/23/2021, after the surveyor entered the facility. She was asked if her investigation included a timeline. She stated, I didn't do a timeline . She was asked if she had staff do a re-enactment of the elopement or checked the distance the resident traveled in the parking lot and she stated, .No, I didn't really know who all was involved . She was asked if she had obtained witness statements regarding when Resident #1 was last seen by staff. The Unit Manager stated, At that time I didn't. She was asked if she knew the 300 Hall Exit Door was malfunctioning. She stated, I don't recall checking the door myself. She was asked if she interviewed or obtained statements from the maintenance staff. She stated, I did not. She was asked if she obtained a statement from Resident #1's Charge Nurse on 7/2/2021. She stated, I did not. She was asked if she got statements from the Certified Nursing Assistants (CNAs) who worked that evening and she stated, I did not . She was asked if she had staff check the other doors after the resident eloped from the facility. She stated, I didn't tell anyone to go check the doors. She was asked what the facility had implemented to keep the residents safe, and she stated, .Walk these halls, listen, make sure they are in their rooms . There was no documentation of a witness statement by the Unit Manager regarding the elopement of Resident #1 in the investigation provided by the facility of the resident's elopement on 7/2/2021. During an interview on 8/27/2021 at 2:18 PM, at the Service Hall Exit Door, Maintenance Assistant #2 stated the exit door had .not been manned when the vendors came, and they were buzzed in . He stated that when the lock on the doors was broken there was not always somebody standing at the doors between the time it is reported and the time, they are able to repair it. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 8/27/2021 at 5:35 PM, the Staff Development Coordinator confirmed the facility did not provide staff education about elopement and wandering residents after the elopement. During a telephone interview on 8/28/2021 at 10:29 AM, CNA #2 confirmed she was preparing to pass ice to the residents when she saw Resident #1 standing in the hall leaning against the wall near her room, and the charge nurse preparing to do blood glucose checks on the residents. She stated it was about 3:30 PM and that was the last time she saw her before she was brought back into the facility. She was asked if anyone had asked her to write a statement regarding the events of that day. She stated, .they had me write it this past Thursday [8/26/2021] before I left, [Named DON] had me write it . During an interview on 8/30/2021 at 12:15 PM, the Unit Manager confirmed the only vital sign that was checked after Resident #1 eloped was a temperature, and that was done at 7:22 PM. She confirmed a complete set of vital signs were not documented as part of the full head-to-toe assessment after Resident #1 eloped. She confirmed that a complete set of vital signs is an important part of the head-to-toe assessment. Refer to F-600, F-609, F-689, F-725, F-726, F-835 and F-867. The facility verified the Removal Plan by: 1. Going forward the facility will complete a thorough investigation which will include getting statements from all staff involved in incidents, do a complete observation of the area, and staff to perform a re-enactment of elopement. The surveyors interviewed the Administrator and the DON. 2. On 8/29/2021 through 8/30/2021, the Chief Operating Officer in-serviced the DON on how to complete a thorough investigation, which includes getting statements from all staff at time of incident, perform a re-enactment, document the response, and the DON and/or the Administrator will review and discuss all the components of the investigation to find ways to ensure the incident does not reoccur with other residents. The surveyors interviewed the DON about conducting an investigation. 3. On 8/29/2021 through 8/30/2021, the Administrator and DON reviewed all incidents to determine whether to report the incident, utilizing the incident/accident log. The surveyors reviewed the incident/accident log and interviewed the Administrator and DON. 4. Starting 8/27/2021, all exit doors will be checked every 30 minutes for the next two weeks, and then will return to daily checks to ensure they are functioning properly. If doors are found not to be functioning properly, the Administrator and/or the DON will be notified, and someone will be assigned to monitor the doors until they are functioning properly. The surveyors reviewed the Door Check sheets to confirm the 30-minute checks were done. 5. The DON will review all new admissions and readmissions the next working day for elopement assessments to ensure timeliness and accuracy. If a resident is determined to be at elopement risk, the Care Plan will be implemented, and a wander guard will be placed on the resident. The surveyors reviewed the DON audits and interviewed the DON. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. On 8/29/2021 through 8/30/2021, staff were in-serviced on abuse, neglect, wandering residents, residents with exit seeking behaviors, and those identified for elopement. The surveyors reviewed the in-services and interviewed staff on all shifts. 7. The facility will utilize the Corporate Compliance Company to review incidents and accidents monthly as oversite. The surveyors interviewed the Chief Operations Officer. 8. The Administrator and/or the DON and Unit Managers will review all incidents immediately by utilizing the incident/accident log and the log will be brought to the morning meeting. The surveyors reviewed the log and interviewed the DON. 9. Any employee who is out on leave will be in-serviced prior to starting work. Noncompliance of F-610 continues at a scope and severity of D for monitoring the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction.

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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** 35806 Based on internet weather site, alarm system company letter, policy review, medical record review, observation, and interview, the facility failed to ensure a safe environment and provide supervision to prevent an incident of elopement, failed to ensure elopement risk assessments were accurate, and failed to ensure exit doors were secure for 1 of 6 sampled residents (Resident #1) reviewed for elopement and wandering behaviors, which resulted in Immediate Jeopardy for Resident #1. On a hot July day Resident #1 eloped through an unlocked exit door on the 300 Hall, walked outside the facility, down the sidewalk and into the back parking lot, traveling approximately 63 feet from the facility. Resident #1, a vulnerable and confused resident, was unsupervised and without staff awareness Resident #1 was outside the facility for approximately 35 minutes. Immediate Jeopardy (IJ) is 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. The Administrator and Director of Nursing (DON) were notified of the Immediate Jeopardy for F-689 on 8/26/2021 at 3:16 PM, in the Conference Room. The facility was cited Immediate Jeopardy at F-689. The facility was cited Immediate Jeopardy at F-689 at a scope and severity of J, which is Substandard Quality of Care. The Immediate Jeopardy for F-689 was effective 7/2/2021 through 8/29/2021. An acceptable Removal Plan, which removed the immediacy of the jeopardy for F-689, was received on 8/28/2021 at 5:38 PM, and was validated onsite by the surveyors 8/29/2021 and 8/30/2021 through policy review, medical record review, observation, education records review, and staff interviews. The findings include: Review of the facility's undated policy titled, MISSING RESIDENT/ELOPEMENTS, revealed .The Unit Charge Nurse is responsible for knowing the location of their residents .Missing Resident Guidelines . Determine time and location when last seen . Review of the facility's policy titled, Wandering, Unsafe Resident, Revised 8/2014, revealed .The facility will strive to prevent unsafe wandering .The staff will identify residents who are at risk for harm because of unsafe wandering (including elopement) .The staff will assess at-risk individuals for potentially correctable risk factors related to unsafe wandering .A missing resident is considered a facility-wide emergency .When the resident returns to the facility, the Director of Nursing Services or Charge Nurse shall .Contact the Attending Physician and report findings and conditions of the resident . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's undated policy titled, CLINICAL SERVICES Subject: Wander Guard [a bracelet device that will trigger the door to alarm when the resident gets too close to the door]/Secure Care Alarm, revealed . Residents that have been identified as an elopement risk will have a wander guard/secure care device applied to ensure their safety . Review of the medical record, revealed Resident #1 was admitted to the facility on [DATE] with diagnoses of Dementia, Cerebral Infarction, Hemiplegia, and Hemiparesis. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 had moderately impaired cognition for decision making and required staff supervision when walking in her room or in the corridor. Review of a Progress Note dated 6/27/2021 at 1:38 PM, revealed .Wandering resident redirected to the 200 hall where her room was located twice before she wandered out of the exit at the end of the 300 hall. She was returned to the inside of the building before the exit door closed behind her . Review of a Progress Note dated 6/27/2021 at 3:13 PM, revealed .Resident [Resident #1] walking away from 200 hall continued to redirect her back to 200 hall Resident stated, ' .going home' . Review of the Elopement Risk Evaluation assessments revealed there was no Elopement Risk Evaluation completed after Resident #1's exit seeking behaviors on 6/27/2021. Review of an Incident Audit Report dated 7/2/2021, revealed .Resident seen outside by therapy assistance [assistant]. Per therapist .As I was exiting the parking lot, I notice [noticed] a resident walking down the walkway .I immediately parked my vehicle and called my direct supervisor to inform her of what was taking place .Resident Description .I am trying to go over [to] my daughter [daughter's] house .I don't want to be here . Review of an undated Speech Language Pathologist Witness Statement, revealed .On Friday, July 2nd, at approximately 4:25p [4:25 PM], I was leaving the building for the day. As I was exiting the parking lot, I notice [noticed] a resident walking down the walkway. I did not witness the resident exiting the building. I immediately parked my vehicle .called my direct supervisor to inform her of what was taking place. I made contact with the resident .asked if she was okay. Resident replied, 'I am looking for my truck' My direct supervisor .and the secretary on [Named Hall] [300 Hall] immediately came out to assist . Review of a Physician Communication Tool dated 7/2/2021, revealed the vital signs were recorded with the date they were obtained and were documented as: Date 3/16/2021 at 11:07 PM Oxygen Saturation 98%, Date 5/27/2021 at 4:15 PM Respiration 18 Date 7/1/2021 at 12:58 PM Pulse 87 Date 7/2/2021 at 9:47 AM Temperature 98.3 Date 7/2/2021 at 9:51 AM Blood Pressure 129/78 (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 vital signs report revealed the only other vital sign documented for Resident #1 on 7/2/2021 was a temperature of 97.3 degrees Fahrenheit at 7:22 PM, approximately 3 hours after Resident #1 was returned to the facility from the parking lot. Review of a Progress Note dated 7/4/2021, revealed .Noted CNA [Certified Nursing Assistant] and Nurse escorting resident from behind the double doors of the service entrance. Noted the entrance door was open and staff was coming in with the trash bin from the kitchen . Review of the 300 Hall Secretary's Witness Statement dated 8/23/2021, revealed On July 2, 2021 around 4:30pm [4:30 PM] I [the secretary's name] heard the alarm going off .by the therapy room. I then went to the door. When I open [opened] the door, I seen [Named Resident #1] standing in the parking lot with [Named Speech Language Pathologist] . Review of the (Named Alarm System Company) letter to the facility dated 8/23/2021, revealed .Regarding: Wander Guard Door Station Repair .Please be advised that on July 29th, 2021, we received, and sent off for repair 2 Wander Guard Door Stations .The 3rd door [300 Hall] station we received was severely damaged, with what appeared to be, a coating of paint on 2/3 of the circuit board .The remaining units were sent in for repair on 7/29/2021 with an estimated turn around of 5-7 weeks .called .to request an updated date on when we might receive the repaired units back. As of this moment, 8/23/2021, we have not been notified of when we can expect them . Review of the recorded temperature data from the Memphis International Airport documented the temperature reached 85 degrees on July 2, 2021. During an interview on 8/23/2021 at 2:15 PM, the Rehabilitation Director stated, I was in my office and [Named Speech Language Pathologist] called me on my cell phone and notified me to make me aware [Named Resident #1] was in the parking lot .informed the secretary on [Named Hall] [300 Hall] why I was going out the door and she came out too. We saw [Named Resident #1] with [Named Speech Language Pathologist] . She said she told Resident #1 she needed to go back inside where it was safe because ' .It's a little warm out here' .I walked her to her room. She was tired, that distance from her room to outside was enough to get her fatigued .[Named CNA #2] watched her, then I went and told [Named Unit Manager] .She didn't know that she was out of the building . During an interview on 8/23/2021 at 2:31 PM, the DON confirmed she had reviewed video footage of Resident #1's elopement. She confirmed Resident #1 exited through the 300 Hall Exit Door next to the therapy department. She stated Resident #1 walked down the sidewalk toward the 300 Hall back door, then she saw the employees bring her inside. The DON was asked if she saw any staff at the 300 Hall Exit Door after Resident #1 exited through the door. She stated, No .I didn't see anybody. I saw staff up the hall picking up meal trays . She was asked if she saw anyone come to the door after Resident #1 exited the building. She stated, No. She confirmed she had not saved the video recording of the elopement and confirmed she did not do a timeline of the incident based on the time stamps on the video. Observation in the Main Dining Room on 8/23/2021 at 2:40 PM, revealed the Maintenance Director checking the Dining Room Exit Door. When he pushed the handle, the door alarmed. Dietary Aide #1 was seated at the kitchen door and did not respond to the alarm. She was asked if she heard the alarm. She stated, No. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 8/23/2021 at 3:05 PM, with the Maintenance Director at the Service Hall Exit Doors, revealed the exit doors would not lock and could be opened easily. He confirmed maintenance staff were working on the doors. He confirmed residents could pass through the double swinging doors and into the Service Hall. Observation on 8/23/2021 at 3:35 PM with the Maintenance Director, at the 800 Hall Dining Room Door, revealed an unlocked padlock on the door. The Maintenance Director stated, .that is supposed to be locked at all times . He confirmed the 800 Hall Dining Room was under construction, there were construction materials in the Dining Room, and residents should not go into the 800 Hall Dining Room. During an interview on 8/23/2021 at 3:35 PM, with the DON, the Unit Manager, and the Administrator, they were asked what the facility implemented when they identified a malfunctioning exit door. The DON stated, . Until it gets fixed .observations of the hallways and the door . During an interview on 8/23/2021 at 4:30 PM, the 300 Hall Secretary stated, .I kept hearing the door alarm, I kept hearing the noise. I started walking that way, and I said, that's the door; no sooner I got to the door .the young lady from therapy .we seen her at the same time out in the parking lot . She confirmed Resident #1 stepped off the sidewalk and walked out into the middle of the parking lot. She stated, .she had got out 2 times .she got out again within the same hour. She got out the door and one of the nurses got her that time . just opened the door, that's when we realized that the door wasn't shutting properly. I really don't know, something with the handle on the door . Observation in the parking lot of the facility on 8/23/2021 at 4:45 PM, revealed the Speech Language Pathologist identified the area where Resident #1 was located after her elopement. The Rehabilitation Director placed red duct tape on the pavement in the middle of the parking lot to mark where Resident #1 was found. Observation in the parking lot of the facility on 8/24/2021 at 8:30 AM, the Physical Therapy Assistant measured the distance from the 300 Hall Exit Door to the marked area where Resident #1 was found after she eloped. The distance measured was approximately 63 feet. During an interview on 8/24/2021 at 10:47 AM, Maintenance Assistant #1 stated, .they called me and said a lady got out and we came up here and found that the door [300 Hall Exit Door] wasn't locking .When we got here, we went straight to the [300 Hall Exit Door] and it opened right up when we pushed it .Something was wrong with the keypad . Observation in the resident's room on 8/24/2021 at 12:15 PM, 8/25/2021 at 2:45 PM, and 8/26/2021 at 10:30 AM, revealed Resident #1 had a wander guard with an elastic string from a face mask, attached to her right ankle. During a telephone interview on 8/24/2021 at 2:20 PM, Licensed Practical Nurse (LPN) #1 confirmed she was the nurse on duty the evening Resident #1 eloped. She was asked when she last saw Resident #1 before she eloped. She stated, .I get 5 sugars [blood glucose checks] on that hall, she's one of them. I start at 3:30 PM .around 3:45 PM, was in room with her doing her sugar [blood glucose check] .next thing I know, they reported she was found in the parking lot . She confirmed it took approximately 5 minutes to perform a blood glucose check. She stated, .When they brought her back in, I checked her out .just wanted to make sure she was ok, it was hot out . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Graceland Rehabilitation and Nursing Care Center	1250 Farrow Road Memphis, TN 38116

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 8/25/2021 at 11:24 AM, the Administrator stated, .from time to time one of those doors would malfunction . She was asked which doors malfunctioned. She stated, .it could be random, we've had to work on the [Named Hall] [300 Hall] door .with ya'll here, we identified the Service Hall Door .If the lock don't secure all the way it might make the door not close .At times the door may not latch .It's an ongoing process, we've gotten several quotes .it's very expensive . The Administrator was asked which doors did not latch. She stated, .I'm not sure .None of them are alarming at the [Nursing] station . During an interview on 8/26/2021 at 9:55 AM, the Maintenance Director confirmed the 800 Hall Dining Room Exit Door was broken, but they kept a padlock with a combination on the door from the hallway into the Dining Room, so no one went in there as it was under construction. The Maintenance Director was asked about the 300 Hall Exit Door. He stated, .We had to fix it temporarily. When you came in, we determined it would not release in the 15 seconds, so we called [Named Alarm System Company]. [Named Maintenance Assistant #2] was supposed to fix it. They said they fixed it. We worked on that door when [Named Alarm System Company] came out, and they checked all the doors. You can put a Phillip's head screwdriver and go inside the keypad .we are going to put tamper proof screws on the keypads. They found that one box in the whole building had a tamper proof screw . He further stated, .You cannot leave a door that is not operating right without somebody watching it .If they [a resident] gets out of this building, it's nothing but trouble. The procedure, we got to watch a door if it's not working. I told [Named DON]. I don't know what's up .something's going on with these doors . Observation on 8/26/2021 at 10:15 AM, revealed the Maintenance Director was checking the door alarm. He pushed on the door and the alarm sounded. No one came out of the kitchen to check the door when the alarm sounded. The Maintenance Director went to the kitchen and asked the staff why they didn't check the alarm. They confirmed they could not hear it. During an interview on 8/26/2021 at 1:06 PM, the Unit Manager was asked when the facility completed elopement risk assessments for all the residents after Resident #1's elopement. She confirmed the facility had not done elopement risk assessments for other residents until 8/23/2021 (51 days after Resident #1 eloped from the facility). She was asked about Resident #1's wander guard receiver. She stated she could not find a wander guard strap and used an elastic string from a face mask to tie the wander guard receiver around Resident #1's ankle. She was asked if staff were to check the other doors after the elopement and stated, .I didn't tell anyone to go check the doors . During an interview on 8/26/2021 at 3:45 PM, the Chief Operating Officer referred to the documented temperature on the day Resident #1 eloped and stated, .84 degrees is not hot .old people like it hot . Observation at the 800 Hall Dining Room door on 8/26/2021 at 4:25 PM, revealed the padlock on the door was not locked and the door had been unsecured by staff. During a telephone interview on 8/27/2021 at 12:05 PM, CNA #1 confirmed she worked the evening Resident #1 eloped. She was asked when she last saw Resident #1 before she eloped. She stated, .I don't remember .she was always walking around in the halls . (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 telephone interview on 8/27/2021 at 2:11 PM, the Medical Director was asked when she was notified of Resident #1's elopement. She stated, .it was probably like that Tuesday [7/6/2021]. She was asked what was reported to her. She stated, .They said the resident known to go up and down the hallway had gone out in the parking lot . The Medical Director was asked what the normal protocol was when a resident eloped, for example did they call her or document it in a book. She stated, If something happens [Named DON] gives me a call .within the next day . During an interview on 8/27/2021 at 2:18 PM, at the Service Hall Exit Door, Maintenance Assistant #2 stated it had not been manned when the vendors came, and they were buzzed in. He stated .when it's broken there's not always somebody standing at the doors in between the time it is reported and the time they work on it and get it fixed . During a telephone interview on 8/28/2021 at 10:29 AM, CNA #2 confirmed she was preparing to pass ice when she saw Resident #1 standing in the hall, leaning against the wall near her room, and the charge nurse was pushing the medication cart down the hall toward Resident #1's room. She stated, .She [Charge Nurse] was going to do the accuchecks [blood glucose checks]. It was about 3:30 [PM]. That's the last time I saw her [Resident #1] before they brought her back. She confirmed the next thing she remembered was about 4:20 PM when she and the therapist returned Resident #1 to her room. She took her to her room, had to change the resident's dress and brief because she was wet. She could not remember what kind of shoes she had on. She bathed her and prepared her for supper. Observation at the Dining Room Door on the 800 Hall on 8/28/2021 at 12:05 PM, revealed Maintenance Assistant #1 looked on the back of the padlock where the combination was written, used that combination to unlock the padlock and opened the dining room door. Inside the dining room was a piece of wood with nails sticking out, a large tube of caulk, containers of latex paint, a piece of wood with screws sticking out, and a container of antibacterial wipes. During an interview on 8/29/2021 at 11:35 AM, LPN #2 confirmed that Resident #1's wander guard receiver was not attached correctly. She stated, .I don't know why it has that string, it's supposed to have a wander guard strap . Observation in the resident's room on 8/29/2021 at 11:45 AM, revealed LPN #2 removed the string used to attach the wander guard receiver to Resident #1's right ankle and replaced it with the wander guard strap. Resident #1 was cooperative and smiled throughout the procedure. During an interview on 8/30/2021 at 12:15 PM, the Unit Manager confirmed the only vital sign obtained after Resident #1 eloped was a temperature, and that was obtained at 7:22 PM. She confirmed a complete set of vital signs were not documented as part of the full head-to-toe assessment after Resident #1 eloped and that a complete head-to-toe assessment would include all vital signs. During an interview on 8/30/2021 at 3:52 PM, the Administrator was asked if the combination to the padlock on the 800 Hall Dining Room Door should be written on the back of the lock. She stated, No, it shouldn't . She was asked if the padlock on the 800 Hall Dining Room Door should always be locked. She stated, Yes. Refer to F-600, F-609, F-610, F-725, F-726, F-835 and F-867. The surveyors verified the Removal Plan: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. On 7/3/2021, Resident #1 was reassessed for elopement risk and was found to be at risk for elopement. Resident #1's Care Plan was updated to reflect elopement and a wander guard was placed on Resident #1 for safety. The surveyors reviewed the Elopement Assessment and Care Plan. 2. On 8/23/2021, all residents were assessed for elopement and no new resident was identified. The surveyors reviewed the Elopement Assessments. 3. On 7/2/2021, the door Resident #1 exited was found not to be latching and the door was immediately repaired. The surveyors checked the doors. 4. Starting 8/27/2021, all exit doors will be checked every 30 minutes for the next two weeks, and then will return to daily checks to ensure they are functioning properly. If doors are found not to be functioning properly, the Administrator and/or the DON will be notified, and someone will be assigned to monitor the doors until they are functioning properly. The surveyors reviewed the Door Check sheets to confirm the 30-minute checks were done. 5. On 8/29/2021 through 8/30/2021, staff were in-serviced on abuse, neglect, wandering residents, residents with exit seeking behaviors, those identified for elopement, to know whom and when to report abuse, and how to start an investigation. The surveyors reviewed the in-services and interviewed staff on all shifts. 6. On 8/26/2021, the Elopement Assessment Tool has been reviewed by the DON and the use of the tool will be in-serviced to all licensed nurses by 9/7/2021. The surveyors reviewed the Elopement Assessment Tool and interviewed nurses on all shifts. 7. On 8/29/2021 through 8/30/2021, staff received education on how to accurately complete the Elopement Risk Assessment. The surveyors reviewed the in-services and interviewed staff on all shifts. 8. On 8/29/2021 through 8/30/2021, the staff were in-serviced on door alarm sounds, and if the exit door alarm was activated, they are to go outside, search the grounds and staff inside the building will ensure all residents are in the facility. The surveyors reviewed the in-services and interviewed staff on all shifts. 9. The DON will review all new admissions and readmissions the next working day for elopement assessments to ensure timeliness and accuracy. If a resident is determined to be at elopement risk, the Care Plan will be implemented, and a wander guard will be placed on the resident. The surveyors reviewed the DON audits and interviewed the DON. 10. The facility will utilize the Corporate Compliance Company to review incidents and accidents monthly as oversite. The surveyors interviewed the Chief Operations Officer. 11. The Administrator and/or the DON and Unit Managers will review all incidents immediately by utilizing the incident/accident log and the log will be brought to the morning meeting. The surveyors reviewed the log and interviewed the DON. 12. Any employee who is out on leave will be in-serviced prior to starting work. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's noncompliance at F-689 continues at a scope and severity of D for monitoring the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 28913 Based on job description review, facility staffing schedules, daily group assignment review, observation, and interview, the facility failed to provide sufficient nursing staff to maintain adequate staffing levels to ensure supervision of residents with wandering and elopement behaviors for 5 of 6 sampled residents (Resident #1, #2, #3, #4, and #6) on 3 of 58 days (7/2/2021, 8/26/2021, and 8/28/2021) reviewed. The findings include: Review of the Administrator Job Description, signed by the Administrator on 7/6/2020, revealed .The primary purpose of your position is to direct day-to-day functions of the Facility in accordance with current federal, state and local standards guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our residents at all time .Personnel Functions .Ensure that an adequate number of appropriately trained licensed professional and non-professional personnel are on duty at all times to meet the needs of the residents. Ensure that appropriate staffing level information is posted on a daily basis. Review and check competence of work force and make necessary adjustments or corrections as required or that may become necessary . Review of the Director of Nursing Services Job Description dated 3/16/2020, revealed .The primary purpose of your position is to plan, organize, develop, and direct the overall operation of our Nursing Services Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern our Facility and as may be directed by the Administrator or the Medical Director to ensure that the highest degree of quality care is maintained at all times .Administrative Function .Assist in calculating the number of direct nursing care personnel on duty each shift. Report such information to the Administrator or his/her designee to ensure that accurate staffing information is posted .Personnel Functions Inform the Nurse Supervisor and/or Unit Manager of staffing needs when assigned personnel fail to report to work . Determine the staffing needs of the nursing service department necessary to meet the total nursing needs of the residents. Supervise and assist scheduling of employees within established state guidelines .Assign a sufficient number of LPN's [Licensed Practical Nurse] and RNs [Registered Nurse] for each tour of duty to ensure that quality care is maintained. Assign a sufficient number of CNAs [Certified Nursing Assistant]/GNAs [Geriatric Nurse Aide] as applicable for each tour of duty to ensure that routine nursing care is provided to meet the daily nursing care needs of each resident .Nursing Care Functions .Provide the Administrator with information relative to the nursing needs of the resident and the nursing service department's ability to meet those needs . Review of the Midnight Census Report dated 7/2/2021 revealed a total census of 124 residents. A total of 55 residents resided on the 100 and 200 Halls. A total of 47 residents resided on the 300 and 400 Halls and a total of 22 residents resided on the 500 and 600 Halls. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Master Schedule for July 2021 revealed the evening shift (2:45 PM-11:15 PM) on 7/2/2021, had 1 CNA scheduled to work the 8-hour evening shift on the 100 and 200 Halls which had 55 residents. There was 1 LPN scheduled to work the 100 and 200 Halls, and 1 Registered Nurse as Unit Manager scheduled to work the evening shift. There were 3 CNAs scheduled to work the 8-hour evening shift on the 300 and 400 Halls with 47 residents. There was 1 CNA scheduled to work the 8-hour evening shift on the 500 and 600 Halls with a total of 22 residents. During an interview on 8/24/2021 at 12:45 PM, the Director of Nursing (DON) was asked how many residents in the facility had wandering behaviors. The DON stated, We don't have any wanderers . Observation in the resident's room on 8/25/2021 at 2:45 PM, revealed Resident #1 had a wander guard receiver (a bracelet device that will trigger the door to alarm when the resident gets too close to the door) tied on her right ankle with an elastic string from a face mask. Resident #1 was asked if she ever went outside. She stated, .I escaped through the fire exit. I was going to my daughter's house . Resident #1 had also exhibited exit seeking behavior on 6/27/2021. On 7/2/2021 Resident #1 exited the building and was observed unsupervised on the parking lot. The staff were unaware the resident was outside the building. Observation in the 500 Hall on 8/28/2021 at 12:45 PM, revealed Resident #2 ambulating in the hallway outside her room. The resident walked independently to the end of the hallway near the exit door. The door alarm did not sound. Resident #2 had a history of wandering and exit seeking behaviors. Resident #3 could independently use a wheelchair for mobility. On 8/24/2021 at 1:15 PM, LPN #2 stated, He [Resident #3] is confused. He comes out sometimes and walks the halls. We have to direct him back. He can't find his way back. He is not coherent .He uses his wheelchair by himself in his room, but he does come out and walk the halls at times . During an interview on 8/24/2021 at 5:15 PM, CNA #2 was asked if Resident #3 was alert and oriented. CNA #2 stated, He just knows he wants to walk. He walks in the halls. He is oriented to self only. No awareness of safety at all. Observation near the 300 Hall Exit Door on 8/23/2021 at 2:40 PM, revealed Resident #4 was pleasantly confused and propelling himself in his wheelchair. He spoke to Maintenance Assistant #2 and stated, .get that door fixed, cuz [because] I'm getting ready to leave . During an interview with the Staffing Coordinator on 8/24/2021 at 2:45 PM, the Staffing Coordinator confirmed that on 7/2/2021, 2 CNAs and 1 LPN worked the evening shift on the 100 and 200 Hall and were responsible for providing care to 55 residents. On 7/2/2021 the 300 and 400 Hall had 3 CNAs and 1 LPN that worked the evening shift to provide care for 47 residents. On 7/2/2021 there was 1 CNA and 1 LPN that worked the evening shift on the 500 and 600 Hall to provide care for 22 residents. When the Staffing Coordinator was asked if 2 CNAs on the evening shift could provide the care the residents needed and monitor wandering residents or residents with exit seeking behavior, she stated, No, ma'am. Review of the Midnight Census Report dated 8/26/2021 revealed a total census of 129 residents. 54 residents resided on the 100 and 200 Halls, 43 residents resided on the 300 and 400 Halls, and a total of 32 residents resided on the 500 and 600 Halls. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Daily Group Assignment sheet dated 8/26/2021, revealed 2 CNAs were assigned to provide care for 32 residents which included 8 residents on the Covid Unit. Observation on 8/26/2021 at 11:45 AM, revealed 1 CNA was assigned to provide care for 24 residents on the 500 and 600 Halls during the day shift. During an interview on 8/26/2021 at 12:58 PM, Unit Manager #1 was asked if 1 CNA assigned to 24 residents on the day shift for the 500 and 600 Halls could provide the care needed for all the residents, including a resident with exit seeking behaviors. Unit Manager #1 stated, .It would be hard. It would be challenging . During a telephone interview on 8/27/2021 at 12:05 PM, CNA #1 confirmed she worked the evening shift on 7/2/2021 when Resident #1 eloped. CNA #1 confirmed the evening of 7/2/2021 she and CNA #2 were responsible for providing care for 55 residents. One CNA was responsible for the care of 27 residents and the other CNA was responsible for the care of 28 residents. CNA #1 was asked if there was enough staff to provide the care the residents needed and supervise the wandering residents. She stated, .that very day, it wasn't enough, to answer call lights, pass meals. Actually, it was difficult. It was not easy for the 2 of us . Observation on 8/27/2021 at 4:10 PM, revealed Resident #6 standing in the doorway of his room. Resident #6 was repeatedly saying, money, my money . Resident #6 followed the surveyor from his room on the 400 Hall to the front of the building. A staff member told him he could not go into the lobby area to the business office. At that time CNA #3 stated, .He wants some of his money. He tries to go through the door all the time to get to the business office that he calls the bank . Review of the Midnight Census Report dated 8/28/2021 revealed a total census of 129 residents. A total of 54 residents resided on the 100 and 200 Halls, a total of 44 residents resided on the 300 and 400 Halls, and a total of 31 residents resided on the 500 and 600 Halls. Observation on 8/28/2021 at 3:50 PM, revealed 1 CNA was assigned to the 8 residents on the designated COVID Unit on the 600 Hall and 1 CNA was assigned to 24 residents on the 500 and 600 Halls for the evening shift. During an interview with LPN #3 on 8/28/2021 at 1:45 PM, LPN #3 confirmed there were 2 CNAs assigned on the day shift to provide care for the 32 residents on the 500 and 600 Halls which included the 8 residents in the COVID Unit. When LPN #3 was asked if 2 CNAs could provide the care needed for the 32 residents, she stated, .Very strenuous to do it all when you have 15 and 16 residents each. It's questionable . During an interview with CNA #6 on 8/28/2021 at 3:50 PM, CNA #6 confirmed she was assigned to provide care for 24 residents on the evening shift. CNA #6 stated, .We are staff challenged .Sometimes I can't get everything done like it should be . During an interview with the DON on 8/28/2021 at 4:15 PM, the DON was asked if there was adequate staffing to provide care and supervision for all residents on each shift. The DON stated, .We have call-ins. We pull staff from other halls. There is a staffing crisis going on nationwide . When asked what plan the facility had implemented to provide adequate staffing, the DON stated, .We are getting a wage analysis. We have been running ads [advertisements] constantly. We have been for a year .

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28913 Based on policy review, elopement risk evaluation review, medical record review, observation, and interview, the facility failed to ensure licensed nurses had the competencies and skill sets necessary to perform assessments and complete elopement risk evaluations for residents with impaired safety awareness to assure safety and provide individualized care for 6 of 6 sampled residents (Resident #1, #2, #3, #4, #5, and #6) reviewed for elopement/wandering behaviors, which resulted in Immediate Jeopardy for Resident #1. Resident #1 eloped on a hot July day through an unlocked exit door on the 300 Hall, walked outside the facility, down the sidewalk and into the back parking lot, traveling approximately 63 feet from the facility. Resident #1 was unsupervised for approximately 35 minutes. The facility's failure to ensure licensed nurses had the competencies and skill sets necessary to perform assessments and complete elopement risk evaluations for residents with impaired safety awareness to assure safety and provide individualized care resulted in Immediate Jeopardy for Resident #2, #3, #4, #5, and #6. Immediate Jeopardy (IJ) is 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. The Administrator and Director of Nursing (DON) were notified of the Immediate Jeopardy for F-726 on 8/27/2021 at 6:38 PM, in the Conference Room. The facility was cited Immediate Jeopardy at F-726. The Immediate Jeopardy was effective 7/2/2021 through 8/29/2021. An acceptable Removal Plan, which removed the immediacy of the jeopardy was received on 8/28/2021, and was validated onsite by the surveyors on 8/29/2021 and 8/30/2021 through policy review, review of education records, medical record review, observation, and staff interviews. The findings include: The facility's undated policy titled, CLINICAL SERVICES Subject: Wander Guard [a bracelet device that will trigger the door to alarm when the resident gets too close to the door]/Secure Care Alarm, revealed . Residents that have been identified as an elopement risk will have a wander guard/secure care device applied to ensure their safety. Procedure: 1. A wander guard will be placed on resident. 2. The device will be checked for placement every shift by the licensed nurse and documented on the TAR [Treatment Administration Record] 3. Resident will be care planned for wandering . Review of the Elopement Risk Evaluation assessment, revealed .Please review all triggers. Residents that exhibit behaviors listed on assessment, have the physical ability to leave unassisted, have attempted elopement in the past, and/or have history of Substance Abuse or Psychosis should be considered at risk for elopement . Review of the Assessment Scoring Categories for the Elopement Risk Evaluation assessments revealed a score of 0 indicated a low risk for elopement and a score of 4 indicated high risk for elopement. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Graceland Rehabilitation and Nursing Care Center	1250 Farrow Road Memphis, TN 38116

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the medical record, revealed Resident #1 was admitted to the facility on [DATE] with diagnoses of Dementia, Cerebral Infarction, Hemiplegia, and Hemiparesis. Review of the Elopement Risk Evaluation assessment dated [DATE], revealed Resident #1 scored 0 on the risk evaluation. Documentation on the risk evaluation completed by the nurse did not include the resident ambulated independently, was unaware of safety needs, and had a diagnosis of dementia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 had moderately impaired cognition for decision making and required staff supervision when walking in her room or in the corridor. Review of a Progress Note dated 6/27/2021 at 1:38 PM, revealed, .Wandering resident redirected to the 200 hall where her room was located twice before she wandered out of the exit at the end of the 300 hall . Resident #1 was brought back inside before she made it outside the door. Review of a Progress Note dated 6/27/2021 at 3:13 PM, revealed, .Resident walking away from 200 hall continued to redirect her back to 200 hall Resident stated, ' .going home' . There was no Elopement Risk Evaluation assessment completed after Resident #1 exhibited exit seeking behavior on 6/27/2021. Review of an Incident Audit Report dated 7/2/2021, revealed, Resident #1 exited the facility and was located in the parking lot by a therapy assistant. Review of a Progress Note dated 7/2/2021 revealed, a Certified Nursing Assistant (CNA) and Nurse escorted the back into the facility. Review of the vital signs history report revealed the only vital sign documented after the elopement incident on 7/2/2021 at 4:30 PM was a temperature of 97.3 at 7:22 PM, approximately 3 hours after Resident #1 was returned to the facility from the parking lot. During an interview on 8/23/2021 at 2:31 PM, the DON was asked if she observed any staff monitoring the 300 Hall exit door after Resident #1 exited through the door. She stated, No .I didn't see anybody. I saw staff up the hall picking up meal trays . Observation in the resident's room on 8/24/2021 at 12:15 PM, 8/25/2021 at 2:45 PM, and 8/26/2021 at 10:30 AM, revealed Resident #1 had a wander guard receiver tied on her right ankle with an elastic string from a face mask. During an interview on 8/26/2021 at 1:06 PM, the Unit Manager was asked when elopement risk assessments were completed for all the residents after Resident #1's elopement. She confirmed the facility had not performed elopement risk assessments for the other residents until 8/23/2021. When the Unit Manager was asked about Resident #1's wander guard receiver attached to the resident's ankle with an elastic string, the Unit Manager confirmed she could not find a wander guard strap and used an elastic string from a face mask to tie the wander guard receiver around Resident #1's ankle. The Unit Manager was asked if other exit doors were checked after the elopement to be certain the residents were safe. The Unit Manager stated, .I didn't tell anyone to go check the doors . (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 8/29/2021 at 11:35 AM, Licensed Practical Nurse (LPN) #2 confirmed Resident #1's wander guard receiver was not attached correctly. She stated, .I don't know why it has that string, it's supposed to have a wander guard strap . During an interview on 8/30/2021 at 12:15 PM, the Unit Manager confirmed the only vital sign checked after Resident #1 eloped was a temperature, and that was done at 7:22 PM. She confirmed a complete set of vital signs and a complete head-to-toe assessment, which would include all vital signs, was not documented after Resident #1 eloped. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Unspecified Psychosis, History of Covid-19, Depressive Episodes, Weakness, Encephalopathy, Hypertension, and Spondylolisthesis. Review of the quarterly MDS assessment dated [DATE], revealed Resident #2 had severely impaired cognition for decision making and ambulated independently. During the MDS assessment period, Resident #2 had wandering behaviors 4 to 6 days. Review of the Physician's Orders dated 3/12/2021 and continued through 6/11/2021, revealed . Wander-guard to right ankle, every shift to prevent elopement. check placement q [every] shift . Review of the Treatment Administration Record (TAR) dated 8/1/2021-8/31/2021, revealed the wander guard placement was not checked on the night shift on 8/14/2021 and the evening shift on 8/16/2021. Review of the Elopement Risk Evaluations dated 6/12/2021 and 8/23/2021, revealed Resident #2 scored 2 on the risk evaluations. Documentation on the risk evaluations completed by the nurse did not include the resident ambulated independently, was unaware of safety needs, and had a history of psychosis. Review of the Care Plan revised on 6/16/2021, revealed the resident had episodes of cutting off the wander-guard with a butter knife from the kitchen with interventions to check the wander guard every shift and as needed for placement and proper functioning. Observation in the resident's room on 8/24/2021 at 11:53 AM, revealed Resident #2 seated on the side of the bed eating lunch, alert with confusion, and had a wander guard bracelet right ankle. Resident #2 was asked if she had a bracelet on her ankle. The resident held up both arms, looked at her wrists and stated, Nope. Observation in the 500 Hall on 8/26/2021 at 12:40 PM, revealed Resident #2 standing in the doorway to her room. She ambulated independently to the end of the hallway and returned to her room after being redirected by CNA #1. Observation in the 500 Hall on 8/28/2021 at 12:45 PM, revealed Resident #2 ambulating in the hallway outside her room and walked independently to the end of the hallway near the exit door. The door alarm did not sound. She was redirected back to her room by LPN #3. Review of the medical record revealed, Resident #3 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Dementia with Behavioral Disturbance, Conversion Disorder with Seizures, Adult Failure to Thrive, Osteoarthritis, and Atrial Fibrillation. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the quarterly MDS assessment dated [DATE], revealed Resident #3 was assessed to have a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment for decision making tasks. He required extensive assistance with transfers and ambulation but was able to propel himself independently in a wheelchair. Review of the Elopement Risk Evaluations dated 7/8/2021 and 8/23/2021, revealed Resident #3 scored 0 on the risk evaluation. Documentation on the risk evaluation completed by the nurse did not include the resident was independent with mobility in a wheelchair, was unaware of safety needs, or had a diagnosis of dementia. During an interview on 8/24/2021 at 1:15 PM, LPN #4 was asked if Resident #3 could independently use a wheelchair for mobility. LPN #4 stated, He is confused. He comes out sometimes and walks the halls. We have to direct him back. He can't find his way back. He is not coherent .He uses his wheelchair by himself in his room, but he does come out and walk the halls at times . Observation on 8/24/2021 at 1:25 PM, revealed Resident #3 seated in a wheelchair at the doorway to his room. He was alert and confused. During an interview on 8/24/2021 at 5:15 PM, CNA #4 was asked if Resident #3 was alert and oriented. CNA #4 stated, He just knows he wants to walk. He walks in the halls. He is oriented to self only. No awareness of safety at all. Review of the medical record, revealed Resident #4 was admitted to the facility on [DATE] with diagnoses of Peripheral Vascular Disease, Chronic Kidney Disease Stage 3, and Dementia. Review of the admission Care Plan dated 8/13/2021, revealed Resident #4 had a self-care deficit and was at risk for falls. Review of the quarterly MDS assessment dated [DATE], revealed Resident #4 had severely impaired cognition for decision making, required extensive assistance with transfers and ambulation, was able to propel the wheelchair independently. Review of the Elopement Risk Evaluation dated 8/13/2021 and 8/23/2021, revealed Resident #4 scored 0 on the risk evaluations. Documentation on the risk evaluations completed by the nurse did not include the resident had exit seeking behavior, wandered without purpose, was independent with mobility in a wheelchair, was unaware of safety needs, and had a diagnosis of dementia. Observation near the 300 Hall Exit Door on 8/23/2021, revealed Resident #4 was pleasantly confused and propelled himself in his wheelchair. He spoke to Maintenance Assistant #2 and stated, .get that door fixed, cuz [because] I'm getting ready to leave . Observation in the resident's room on 8/24/2021 at 4:02 PM, revealed Resident #4 seated in a wheelchair. He pointed to a bare wall and stated, .use that phone .get my wife on the phone and she can come pick me up and drop me off . Review of the medical record, revealed Resident #5 was admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease, Cerebral Infarction, Vascular Dementia, Hemiparesis, and Hemiplegia. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the quarterly MDS dated [DATE], revealed Resident #5 had severe cognitive impairment for decision making and required supervision when using a wheelchair. Review of the Elopement Risk Evaluation dated 6/20/2021, revealed Resident #5 scored 0 and on 8/23/2021 scored 1 on the risk evaluation. Documentation on the risk evaluation completed by the nurse did not include the resident was unaware of safety needs or had a diagnosis of dementia. During an interview on 8/27/2021 at 3:07 PM, LPN #4 was asked if the 6/20/2021 and 8/23/2021 Elopement Risk Evaluations were accurate. LPN #4 confirmed the assessments were inaccurate and confirmed Resident #5 did not have good safety awareness and the resident had dementia. Review of the medical record, revealed Resident #6 was admitted to the facility on [DATE] with diagnoses of Schizophrenia, Parkinsonism, Hallucinations, Cerebrovascular Disease, Convulsions, and Aphasia. Review of the annual MDS dated [DATE], revealed Resident #6 had moderate cognitive impairment for decision making and was independent in all activities of daily living. Review of the Elopement Risk Evaluation dated 6/2/2021, revealed Resident #6 scored 1 and on 8/23/2021 scored 0 on the risk evaluation. Documentation on the risk evaluation completed by the nurse did not include the resident was unaware of safety needs, independent in ambulation, or had a diagnosis of psychosis. Observation in the doorway to the resident's room on 8/27/2021 at 4:10 PM, revealed Resident #6 standing. Resident #6 was repeatedly saying, money, my money . Resident #6 followed the surveyor from his room on the 400 Hall to the front of the building. A staff member told him he could not go into the lobby area to the business office. At that time CNA #3 stated, He wants some of his money. He tries to go through the door all the time to get to the business office that he calls the bank. During an interview on 8/25/2021 at 3:20 PM, LPN #1 was asked when elopement/wandering risk assessments were to be completed. LPN #3 stated, On admission or if they eloped or had verbalizations of leaving . LPN #3 was asked when a wander guard would be placed on a resident. LPN #3 stated, If the resident is going to the door and trying to open the door to leave .I have a wander guard on the cart. I would need to get a band. Not sure where the bands are kept. Maybe someone has one on another cart . During an interview on 8/25/2021 at 3:36 PM, the DON was asked when elopement/wandering risk assessments should be completed. The DON stated, On admission, if we identify someone trying to exit, and quarterly .Didn't see a need to do an assessment on all the residents . During an interview on 8/26/2021 at 1:10 PM, the DON was asked what the score on the Elopement Risk Evaluation indicated. The DON stated, We don't use a score. The computer generates and tells us if the resident is an exit seeking risk. It automatically tells us at the bottom. The DON was asked what the score for a wandering resident with a high risk of elopement would be. The DON stated, We don't use a score .If a resident is going to a door and trying to open the door to get out that would be a high risk. I didn't know there was a score . (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 8/28/2021 at 1:55 PM, LPN #3 was asked if the wander guard bracelet device would trigger the exit doors to alarm. LPN #3 stated, .I've wondered about this alarm they use on the bracelets here. They don't cause the door to alarm and they don't cause the door to lock. They don't do anything. I've not been told exactly what the wander bracelet is for except if exit-seeking the resident is to have one on. We are to check to make sure it is on and working each shift . The surveyors verified the Removal Plan by: 1.The Administrator and DON will implement an audit form for any resident found to be exit seeking or wandering. The form will be on all Nurses' Stations where the resident resides. This was confirmed by review of the audit form and interview with the Administrator, DON, and Unit Manager. 2. An elopement book will be kept at each Nurses' Station with the resident name, picture, and room number. This was verified through interview with the staff at each Nurses' Station and observation of each elopement book. 3. The Administrator will review the elopement books for accuracy weekly. This was confirmed by interview with the Administrator. 4. A neon colored bracelet will be applied to the body of each exit seeking resident by 9/7/2021. Extra bracelets will be kept on each medication cart with a wander guard device. This was confirmed by interview with the DON, the Unit Manager, staff on all 3 shifts, and review of the invoice order for the neon colored bracelets. 5. Maintenance will be responsible for checking the outside grounds Monday-Friday and report any hazards to Administrator. This was confirmed by review of an audit form and interview with the Maintenance Director. 6. Starting 8/27/2021, all exit doors will be checked every 30 minutes for the next two weeks, and then will return to daily checks to ensure they are functioning properly. If doors are found not to be functioning properly, the Administrator and/or the DON will be notified, and someone will be assigned to monitor the doors until they are functioning properly. The surveyors reviewed the Door Check sheets to confirm the 30-minute checks were done. 7. On 8/29/2021 through 8/30/2021, staff were in-serviced on abuse, neglect, wandering residents, residents with exit seeking behaviors, those identified for elopement, to know whom and when to report abuse, and how to start an investigation. The surveyors reviewed the in-services and interviewed staff on all shifts. 8. On 8/26/2021, the Elopement Assessment Tool has been reviewed by the DON and the use of the tool will be in-serviced to all licensed nurses by 9/7/2021. The surveyors reviewed the Elopement Assessment Tool and interviewed nurses on all shifts. 9. On 8/29/2021 through 8/30/2021, staff received education on how to accurately complete the Elopement Risk Assessment. The surveyors reviewed the in-services and interviewed staff on all shifts. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	10. On 8/29/2021 through 8/30/2021, the staff were in-serviced on door alarm sounds, and if the exit door alarm was activated, they are to go outside, search the grounds and staff inside the building will ensure all residents are in the facility. The surveyors reviewed the in-services and interviewed staff on all shifts. 11. The DON will review all new admissions and readmissions the next working day for elopement assessments to ensure timeliness and accuracy. If a resident is determined to be at elopement risk, the Care Plan will be implemented, and a wander guard will be placed on the resident. The surveyors reviewed the DON audits and interviewed the DON. 12. Any employee who is out on leave will be in-serviced prior to starting work. 13. The DON will monitor staff education by holding monthly mandatory in-services with staff identifying any concerns and review the policies. This was confirmed by interview with the DON. The next in-service was scheduled for 9/23/2021. The facility's noncompliance at F-726 continues at a scope and severity of E for monitoring the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35806 Based on Board of Examiners of Nursing Home Administrators (BENHA) review, job description review, medical record review, observation, and interview, the facility Administration failed to provide supervision and oversight to prevent the potential for serious injury and harm when Resident #1 eloped on a hot July day through an unlocked exit door on the 300 Hall, walked outside the facility, down the sidewalk, and into the back parking lot which was approximately 63 feet from the facility. Resident #1, a vulnerable and confused resident, was unsupervised for approximately 35 minutes. Immediate Jeopardy (IJ) is 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. The Administrator and the Director of Nursing (DON) were notified of the Immediate Jeopardy on 8/27/2021 at 6:38 PM, in the Conference Room. The facility was cited Immediate Jeopardy at F-600, F-609, F-610, F-689, F-726, F-835, and F-867. The facility was cited Immediate Jeopardy at F-600, F-609, F-610, and F-689 at a scope and severity of J, which is Substandard Quality of Care. The facility was cited an Immediate Jeopardy at a J on 2/10/2020 for deficiencies related to F-600, F-610, F-689, F-835 and F-867. The Immediate Jeopardy was effective from 7/2/2021 through 8/30/2021. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on 8/28/2021 at 5:38 PM, and was validated onsite by the surveyors on 8/29/2021 and 8/30/2021 through observations, review of audits, meeting minutes, and staff interviews. The findings include: Review of the BENHA revealed the Administrator had an employment date of 7/6/2020. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Administrator job description, signed by the Administrator on 7/6/2020, revealed .The primary purpose of your position is to direct the day-to-day functions of the Facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our residents at all times .As Administrator, you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties . Administrative Functions .Plan, develop, organize, implement, evaluate, and direct the Facility's programs and activities in accordance with guidelines issued by the VP [Vice President] of Operations .Develop and maintain written policies and procedures and professional standards of practice that govern the operation of the Facility .realize the importance of teamwork .Review the Facility's policies and procedures at least annually and make changes as necessary to assure continued compliance with current regulations .Ensure that all employees, residents, visitors, and the general public follow the Facility's established policies and procedures .Represent the Facility in dealings with outside agencies, including governmental agencies . Participate in state/federal surveys of the facility .Assist in providing survey team members with additional information during the survey .Review deficiencies noted during the exit conference .Assist the Quality Assurance and Assessment Committee in developing and implementing appropriate plans of action to correct identified quality deficiencies .Consult with department directors concerning the operation of their departments to assist in eliminating and correcting problem areas .Ensure that an adequate number of appropriately trained licensed professional and non-licensed personnel are on duty at all times to meet the needs of the residents .Review and check competence of work force and make necessary adjustments or corrections .Inform the Medical Director of all suspected or known incidents of resident abuse .Ensure the building and grounds are maintained in good repair .Review accident/incident reports .Monitor to determine the effectiveness of the facility's risk management program .Specific Requirements .Must have a thorough knowledge of OBRA [Omnibus Budget Reconciliation Act] regulations, the survey process, survey tag numbers, and quality measures .Must be able to communicate policies, procedures, regulations, reports .to government agencies and personnel . (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Director of Nursing Services job description, signed by the DON on 3/16/2020, revealed .The primary purpose of your position is to plan, organize, develop and direct the overall operation of our Nursing Service Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern our Facility .you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties. In the absence of the Medical Director, you are charged with carrying out the resident care policies established by the Facility .Plan, develop, organize, implement, evaluate, and direct the nursing service department, as well as its programs and activities, in accordance with current rules, regulations, and guidelines that govern the nursing care facilities .Develop, implement, and maintain an ongoing quality assurance program for the nursing service department .Assist the Quality Assessment & [and] Assurance Committee (QAPI) in developing and implementing appropriate plans of action to correct identified deficiencies .Make daily rounds of your unit/shift to ensure that assigned CNAs [Certified Nursing Assistants] .and other nursing personnel are performing their work assignments in accordance with acceptable nursing standards .Make changes to assignments based upon resident needs . Determine the staffing needs of the nursing service department necessary to meet the total nursing needs of the residents .Assign a sufficient number of LPNs [Licensed Practical Nurses] and RNs [Registered Nurses] for each tour of duty to ensure that quality care is maintained .Assign a sufficient number of CNAs for each tour of duty to ensure that routine nursing care is provided to meet the daily nursing care needs of each resident .Review nurses' notes to ensure that they are informative and descriptive of the nursing care being provided, that they reflect the resident's response to the care .Develop and participate in the planning, conducting, and scheduling of timely in-service training classes that provide instructions on how to do the job, and ensure a well-educated nursing service department .Monitor nursing service personnel to ensure that they are following established safety regulations in the use of equipment and supplies .Review and revise care plans and assessments as necessary .Report all allegations of resident abuse .Must be knowledgeable of nursing and medical practices and procedures, as well as laws, regulations, and guidelines that pertain to nursing care facilities . The facility's partial investigation provided to the surveyors on 8/23/2021 at 12:05 PM included an Incident Audit Report dated 7/2/2021 that documented 4 accounts of the events of that day: a. The resident was observed in the parking lot unattended; an undated handwritten statement that the employee was leaving the facility, saw the resident in the parking lot, contacted the supervisor, and the secretary on the 300 Hall came to assist; b. An Elopement assessment dated [DATE], documented the resident was assessed, the Doctor of Nursing Practice, Psychologist and Responsible Party were notified, an Elopement/Wandering monitoring report was implemented, and an Elopement Risk assessment was completed; c. A Situation Background, Assessment Recommendation (SBAR - a short, organized and predictable flow of information between professionals) was completed. The Care Plan was updated, and the Incident was placed on the 24-hour report. d. An SBAR with documentation of Vital Signs. The facility's investigation did not include interviews/statements from other staff working on the day of the elopement, did not include interviews/statements from staff working on previous shifts, did not include elopement assessments of other residents, did not include monitoring all doors, and did not include interviews with the maintenance department staff regarding the doors. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Graceland Rehabilitation and Nursing Care Center	1250 Farrow Road Memphis, TN 38116

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #1 exited the facility into the facility parking lot unattended on 7/2/2021 and was unsupervised for approximately 35 minutes. Facility Administration failed to report the incident to the State Agency or Adult Protective Services and failed to conduct a thorough investigation after Resident #1 eloped from the facility. During an interview on 8/23/2021 at 12:30 PM, the Director of Nursing (DON) confirmed the facility had not reported the elopement and stated, .I didn't know we had to . During an interview on 8/23/2021 at 2:31 PM, the Director of Nursing (DON) confirmed she had reviewed video footage of Resident #1's elopement but had not saved the video recording of the elopement and confirmed she did not do a timeline of the incident based on the time stamps on the video. Observation on 8/23/2021 at 3:05 PM, at the Service Hall Exit Doors, with the Maintenance Director, revealed the exit doors would not lock and could be opened easily. He confirmed residents could pass through the double swinging doors and into the Service Hall. During an interview on 8/23/2021 at 3:35 PM, the DON, Unit Manager, and Administrator were asked what the facility implemented when they identified a malfunctioning exit door. The DON stated, .Until it gets fixed . observations of the hallways and the door . During an interview on 8/24/2021 at 5:30 PM regarding the regulations on neglect and elopement, the Administrator stated, .I didn't know the regulation changed. I hadn't read the regulations . During an interview on 8/24/2021 at 5:35 PM, the DON stated, .I didn't know the change in the regs [regulations] where .elopement is moving from a safe place to an unsafe place .I went by 2016 regs . During an interview on 8/25/2021 at 11:24 AM, the Administrator was asked if she had reviewed the video camera footage. She stated, I did not. I did not think about saving it . The Administrator was asked if the DON had written a timeline based on the time stamps on the video camera footage of the elopement. She stated, No . The Administrator stated, .from time to time one of those doors would malfunction. She was asked which doors malfunctioned. She stated, .it could be random, we've had to work on the [Named Hall] [300 Hall] door .with ya'll here, we identified the Service Hall Door .If the lock don't secure all the way it might make the door not close .At times the door may not latch . The Administrator was asked which doors do not latch. She stated, .I'm not sure .None of them are alarming at the [Nursing] station . The Administrator stated, We could have investigated more. We didn't consider it an elopement . During an interview on 8/25/2021 at 11:40 AM, the DON stated, .I don't read the regs .I'm being honest with you . During an interview on 8/25/2021 at 11:45 AM, the Administrator stated, .I didn't know the regs said potential. I thought the verbiage said likely. I didn't read the regs .I read it after the [Named Surveyor] told us about it . (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 8/26/2021 at 2:20 PM, the Administrator was presented the IJ template for F-689. She looked at it and stated loudly, .We did everything .we are not going to take this IJ!!! She referred to the approximate amount of time the resident was missing and stated loudly, .approximate means exactly! The surveyor attempted to explain the definition of approximate, and the Administrator interrupted and shouted, .it means exactly! The Administrator placed both her arms on the conference table and leaned toward the surveyor and shouted, .we are in compliance! You are out of compliance! I am calling CMS [Center for Medicare Services] and your supervisors! She stormed out of the room, leaving the surveyors seated in the Conference Room with the 4 IJ templates for F-689, F-609, F-610, and F-867. During a telephone interview on 8/27/2021 at 2:11 PM, the Medical Director was asked when she was notified about Resident #1's elopement. She stated, .it was probably like that Tuesday [July 6, 2021]. She was asked what was reported to her. She stated, .They said the resident known to go up and down the hallway had gone out in the parking lot . The Medical Director was asked what the normal protocol was after a resident eloped. She stated, If something happens [Named DON] gives me a call .within the next day . During an interview with the Administrator on 8/27/2021 at 3:42 PM, the Administrator was asked if a Quality Assurance Performance Improvement (QAPI) ad hoc (when needed) meeting was held after the elopement incident on 7/2/2021. The Administrator stated, I don't know what date. When asked if other residents were assessed to determine the risk of elopement after the incident occurred, the Administrator stated, I don't know .did frequent monitoring of [Named Resident #1] for July. When asked to define frequent, the Administrator stated, Not sure what [Named DON] put in place. I didn't question her . During an interview on 8/27/2021 at 5:35 PM, the Staff Development Coordinator confirmed the facility did not provide staff education about elopement and wandering residents after the elopement incident. Administration failed to timely assess a resident with wandering and exit seeking behaviors, failed to ensure a safe environment for a wandering and exit seeking resident, failed to thoroughly investigate an incident of elopement, and failed to report the resident's elopement to the State Agency. Refer to F-600, F-609, F-610, F-689, F-726, and F-867. The surveyors verified the Removal Plan by: 1. On 8/27/2021, the Administrator will in-service the DON on when to report any form of abuse and how to complete a thorough investigation. The surveyors reviewed the education and interviewed the DON and Administrator. 2. The facility will utilize a Corporate Compliance Company to review incidents and accidents monthly as oversight. The Surveyors interviewed the Corporate Compliance Officer. 3. On 8/30/2021, Administration presented a plan for daily staff meetings to identify any risk of elopement/neglect/abuse. The surveyors reviewed the daily staff meeting minutes. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. The Chief Operating Officer (COO) will educate and monitor the DON and Administrator weekly. The surveyors interviewed the COO. 5. All investigations will be addressed in monthly Quality Assurance Performance Improvement (QAPI) meetings and Ad Hoc will be done within 2 hours of the incident. The surveyors interviewed QAPI members. 6. The Administrator will round with Maintenance 3 times a week to ensure all exit doors are functioning properly. The surveyors interviewed the Administrator. 7. Meetings will be held Monday through Friday to identify any new possible elopement risk residents. The surveyors interviewed the Administrator. 8. On the weekends, the RN Supervisor will round to identify any possible wanderers and exit seeking residents. The surveyors interviewed the RN Supervisors. 9. Elopement/Exit Seeking/Wanderer audit form has been implemented to ensure compliance is met and maintained in order to ensure the policy and procedures are being adhered to. The surveyors reviewed the audit form. 10. The facility has established a system for all staff if a resident is found trying to exit the facility. The system is RATS (R-redirect the resident to a safe area, A-ask the residents questions concerning why they are trying to leave, T-tell your supervisor what you saw and write a statement, S-Supervisor/designee to start an investigation). The surveyors interviewed staff on all shifts. The facility's noncompliance at F-835 continues at a scope and severity of E for monitoring the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction.

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 28913 Based on policy review, Quality Assurance Performance Improvement (QAPI) Committee meeting review, job description review, and interview, the QAPI committee failed to ensure systems and processes were in place and consistently followed by staff to address safe individualized resident care when the committee failed to ensure an effective QAPI program was implemented, failed to ensure the completion of a thorough investigation and reporting of an incident of elopement, and failed to use it's resources effectively in order to provide supervision and a safe environment for residents. The failure of the QAPI committee to ensure systems and processes were in place and systems were consistently followed by staff and administration placed Resident #1, a vulnerable resident with exit seeking behavior, in Immediate Jeopardy when Resident #1 eloped on a hot July day through an unlocked exit door on the 300 Hall, walked outside the facility, down the sidewalk and into the back parking lot, traveling approximately 63 feet from the facility. The facility staff were unaware the resident was missing from the facility for approximately 35 minutes. This resulted in Immediate Jeopardy for Resident #1. Immediate Jeopardy (IJ) is 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. The Administrator and the Director of Nursing (DON) were notified of the Immediate Jeopardy on 8/27/2021 at 6:38 PM, in the Conference Room. The facility was cited Immediate Jeopardy at F-600, F-609, F-610, F-689, F-726, F-835, and F-867. The facility was cited Immediate Jeopardy at F-600, F-609, F-610, and F-689 at a scope and severity of J, which is Substandard Quality of Care. The facility was cited an Immediate Jeopardy at a J on 2/10/2020 for deficiencies related to F-600, F-610, F-689, F-835 and F-867. The Immediate Jeopardy was effective 7/2/2021 through 8/29/2021. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on 8/28/2021, and was validated onsite by the surveyors 8/29/2021 and 8/30/2021 through policy review, medical record review, observation, review of education records, and staff interviews. 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 - Some	Review of the facility policy titled QA [Quality Assurance] Committee-Role of the Quality Assessment and Assurance Coordinator, revised 11/2010, revealed .Duties and responsibilities of the Quality Assessment and Assurance Program include, but are not limited to: .Meeting with the Quality Assessment and Assurance Committee monthly to review all assessment tools designed, all data collection reports, and all activities regarding quality assessment and assurance as carried out by departments, services, or committees which have a direct impact on resident care and safety .planning developing, organizing, implementing, coordinating, and directing the Quality Assessment and Assurance program designed to enhance the quality of resident care, in accordance with current rules, regulations, and guidelines that govern the long-term care facility .Evaluating programs and effecting changes as necessary to improve programs and assuring compliance with regulatory requirements .Assisting department directors in developing and implementing appropriate plans of action to correct identified deficiencies .Scheduling committee meetings and notifying members of such meetings .Assisting in developing follow-up procedures for monitoring identified problem areas . Review of the facility's policy titled, Wandering, Unsafe Resident, revised 8/2014, revealed .The staff will identify residents who are at risk for harm because of unsafe wandering (including elopement) .The staff will assess at-risk individuals for potentially correctable risk factors related to unsafe wandering .When the resident returns to the facility, the Director of Nursing Services or Charge Nurse shall .Complete and file an incident report; and Document relevant information in the resident's medical record . Review of the Administrator Job Description, signed by the Administrator on 7/6/2020, revealed .The primary purpose of your position is to direct day-to-day functions of the Facility in accordance with current federal, state and local standards guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our residents at all times .Committee Functions Serve on various committees of the Facility (i.e. Infection Control, Quality Assurance and Assessment, etc. and provide written and oral reports of such committee meetings to the VP [Vice President] of Operations .Assist the Quality Assurance and Assessment Committee in developing and implementing appropriate plans of action to correct identified quality deficiencies. Evaluate and implement recommendations from the Facility's committee as necessary . Review of the Director of Nursing Services Job Description, signed by the Director of Nursing on 3/16/2020, revealed .The primary purpose of your position is to plan, organize, develop, and direct the overall operation of our Nursing Services Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern our Facility and as may be directed by the Administrator or the Medical Director to ensure that the highest degree of quality care is maintained at all times .Duties and responsibilities .Plan, develop, organize, implement, evaluate, and direct the nursing services department, as well as its programs and activities in accordance with current rules, regulations, and guidelines that govern the nursing care facilities .Develop, implement, and maintain an ongoing quality assurance program for the nursing service department .Assist the Quality Assurance and Assessment Committee in developing and implementing appropriate plans of action to correct identified deficiencies . An ad hoc (when needed) QAPI meeting was not conducted immediately following the elopement of Resident #1. Review of the QAPI meeting minutes provided by the Administrator, revealed QAPI Committee meetings were held on 7/28/2021 and 8/23/2021. There was no immediate action taken by the QAPI Committee to keep all residents with wandering behaviors safe after the elopement of Resident #1 on 7/2/2021. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 8/23/2021 at 12:30 PM, the DON confirmed the elopement incident had not been reported to the State Agency. The DON stated, .I didn't know we had to [report]. She [Resident #1] didn't get off the property . During an interview on 8/23/2021 at 2:31 PM, the DON confirmed she had viewed the video camera footage after the elopement incident. The DON stated, .[Named Resident #1] exited from the therapy exit door on the video. If they [residents] don't get off the premises, it's not an elopement .I didn't keep the video because I didn't think I had to report it . During an interview on 8/25/2021 at 11:24 AM, the Administrator was asked if she reviewed the camera footage. The Administrator stated, I did not look at the camera footage. The cameras automatically erase after 5 days. When asked if the DON documented times of the elopement incident from the video footage, the Administrator stated, Not that I know of. I can ask her . The Administrator was asked what had been implemented after the incident occurred to provide a safe environment for residents that may wander and/or are exit seeking. The Administrator stated, .We QA'd [Quality Assurance] the doors. The doors malfunction at times by making a beeping noise. [Named Hall] [300 Hall], the therapy door, does that. This week we identified the service door was a problem. At times the doors may not latch. When asked which doors she was referring to, the Administrator stated, I'm not sure .We are replacing all the doors. One has been replaced . When asked which door had been replaced, the Administrator stated, I don't know .The nurse is making sure she is checking on all the residents more often. I don't know how often. [Named DON] has something in place for that .I do feel like we did what we could do. We put the wander guard on, and the notifications were made. We could have investigated more. We didn't consider it an elopement .I didn't know the regs [regulations] said potential. I thought the verbiage said likely. I didn't read the regs. I read it after [Named Surveyor] told us about it. During a telephone interview with the Medical Director on 8/27/2021 at 2:11 PM, the Medical Director was asked if a QAPI ad hoc meeting was held to discuss the elopement incident. She stated, .Probably called me that Tuesday [7/6/2021]. They said she [Resident #1] had gotten into the parking lot and they had gotten her and brought her back inside. When asked when she attended an ad hoc meeting, the Medical Director stated, Some days to a week, maybe 2 weeks. I had to do it by phone if I'm not mistaken. Discussed being able to watch that patient [Resident #1]. Wasn't told of anything else in place . When asked if there was any discussion about the function of the doors in the ad hoc meeting that was held 2 weeks later, the Medical Director stated, No. During an interview with the Administrator on 8/27/2021 at 3:42 PM, the Administrator was asked if a QAPI ad hoc meeting was held after the elopement incident on 7/2/2021. The Administrator stated, I don't know what date. When asked if other residents were assessed to determine risk of elopement after the incident occurred, the Administrator stated, I don't know .did frequent monitoring of [Named Resident #1] for July. When asked to define frequent, the Administrator stated, Not sure what [Named DON] put in place. I didn't question her . During an interview on 8/27/2021 at 5:35 PM, the Staff Development Coordinator confirmed the facility did not provide staff education about elopement and wandering residents after the elopement incident. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility's QAPI Committee failed to identify the immediate need for an ad hoc meeting to discuss the resident elopement, failed to investigate the elopement thoroughly, failed to analyze the situation, and evaluate possible regulatory concerns related to Resident #1's elopement from the facility to ensure the safety of all residents with wandering and/or exit seeking behaviors. Refer to F-600, F-609, F-610, F-689, F-726, and F-835. The surveyors verified the Removal Plan by: 1. QAPI committee members will be in-serviced on how to properly identify residents with wandering/exit seeking behaviors and review the policy. QA committee members will be instructed on how to start an investigation. This was confirmed by interview with the Administrator and DON and review of the meeting sign-in sheet of committee members. 2. In the event of elopement, or any form of abuse, the Administrator and DON will discuss all components of the investigation to find ways to ensure the incident does not reoccur with other residents. This was confirmed by interview with the Administrator and DON. 3. Staff will be educated on how to use RATS (an acronym for Redirect, Ask questions, Tell Someone, write Statement). This was confirmed by interview with staff from all 3 shifts and review of the in-service sheet with employee signatures. 4. Maintenance will use REQQR (a web-based maintenance management tool) to track repairs and report. This was confirmed by interview with the Chief Operations Officer (COO), the Administrator and 3 Maintenance staff. 5. The COO will perform a QAPI in-service monthly and will be monitored by an outside consultant in the Corporate Compliance Company. This was confirmed by interview with the COO, the Corporate Compliance Consultant, and the Administrator. 6. Monthly audits will be conducted by the Corporate Compliance Company on incidents and accidents as oversight. This was confirmed by interview with the Corporate Compliance Consultant. The facility's noncompliance at F-867 continues at a scope and severity of E for monitoring the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35806 Based on policy review, medical record review, staff time punch reports, employee screening logs, observation, and interview, the facility failed to follow Contact Isolation Precautions when 1 of 3 staff members (Certified Nursing Assistant (CNA) #3) touched the inside of a meal cart and failed to don (apply) and wear gloves when entering resident rooms on the Covid-19 Unit, where 8 residents resided; and failed to remove Personal Protective Equipment (PPE) before exiting the Covid-19 Unit, which could affect the residents not residing on the COVID-19 Unit; the facility failed to properly isolate residents exposed to Covid-19 for 4 of 4 sampled residents (Resident #8, #10, #12, and #14) reviewed that were exposed to COVID-19; and the facility failed to properly prevent and contain COVID-19 when 2 of 142 staff members (Housekeeper #2 and #3) failed to complete the COVID-19 screening logs on 5 of 15 days (8/11/2021, 8/12/2021, 8/14/2021, 8/19/2021, and 8/22/2021) reviewed, which could have affected the residents these housekeeping staff members came in contact with. The findings include: Review of the facility's undated policy titled, .PPE [Personal Protective Equipment] Guidelines: What, When, Wear, revealed .caring for or encountering a COVID+ [positive] or COVID suspected or COVID unknown resident .FACE SHIELD OR GOGGLES .GLOVES .FIT-tested N95 RESPIRATOR .GOWN . Review of the facility's undated policy titled, .Personal Protective Equipment (PPE), revealed .To ensure that . PPE .is provided for all staff at the facility, including .facemasks, gloves, gowns, and eye protection .when interacting with COVID-19 suspected or confirmed residents .Prior to entering areas where residents are suspected or confirmed with COVID-19 .Education provided to staff on proper usage, procedure, and sequence for donning, removing and discarding PPE . Review of the facility's undated policy titled, .Contact Precautions, revealed .Transmission Based Precautions are designed for residents documented or suspected to be infected or colonized with highly transmissible or epidemiologically important pathogens for which additional precautions beyond stand precautions are needed to interrupt transmission .Equipment .Door sign that reads 'Contact Precautions' or 'Visitors Must See Nurse Before Entering' or notifies visitors to check at front desk . Review of the facility's undated policy titled, Employee Screening, revealed .The purpose of this policy is to ensure that all employees are screened prior to beginning work .Prior to working screening .Employee . sanitizes hands .The employee's temperature is taken .The employee is screened for .Fever, SOB [Shortness of Breath] or difficulty breathing, Muscle pain, Chills, Sore throat, Cough, New loss of taste or smell .Contact with person with COVID-19 or travel to affected areas .Employees must have a successful screening and must have no identified issues to be allowed to work . Observation in the COVID Unit located on the 600 Hall on 8/24/2021 at 4:48 PM, revealed CNA #3 standing in the COVID Unit near the unzipped barrier wearing full PPE. A meal cart was at the barrier entrance, was open, CNA #3 was reaching into the meal cart and touching items in the cart. CNA #3 saw the surveyor and shouted to the Unit Manager #2, We have a problem! CNA #3 stepped out of the COVID Unit, removed her PPE, rolled it up in her hands, stepped back into the COVID Unit without donning PPE, and placed the used PPE in the trash bin inside the COVID Unit. She then came out of the COVID Unit and performed hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of the COVID Unit on the 600 Hall on 8/24/2021 at 4:58 PM, revealed CNA #3 donned full PPE outside the COVID Unit and stepped inside the COVID Unit. CNA #3 obtained a tray from a staff member on the other side of the COVID Unit barrier and carried it into a resident room, she came out of the room, removed her gloves, and performed hand hygiene. She did not don new gloves between serving other residents in the COVID Unit. During an interview on 8/24/2021 at 5:05 PM, Unit Manager #2 was asked if CNA #3 should have come out of the COVID Unit and removed the PPE in the hall outside the COVID Unit. She stated, No, she should have stayed in the unit and removed her PPE and discarded it then . During an interview on 8/27/2021 at 11:30 AM, the Infection Control Preventionist was asked if staff, dressed in full PPE and standing inside the COVID Unit should touch the inside of the meal tray cart. She stated, .she should not be in the cart. Someone should be handing her the trays. She was asked if staff should leave the COVID Unit, dressed in full PPE, remove their PPE outside the COVID Unit, and then return to the COVID Unit to place the PPE in the trash. She stated, She should not have done that. She should have taken it [PPE] off in the COVID Unit. Everything should be taken off in the COVID Unit, before leaving the Unit . She confirmed staff should not enter resident rooms in the COVID Unit without wearing gloves. Review of the medical record, revealed Resident #7 was admitted to the facility on [DATE] with diagnoses of Diabetes Mellitus, Cerebral Infarction, Hemiplegia, Hemiparesis, and Dementia. Review of a Test Result dated 8/19/2021, revealed Resident #7 tested positive for COVID-19. Review of the medical record, revealed Resident #8 was admitted to the facility on [DATE] with diagnoses of Congestive Heart Failure, Peripheral Vascular Disease, and Hypertension. Review of a Midnight Census Report dated 8/19/2021, revealed Resident #7 and Resident #8 were roommates, and Resident #8 was exposed to COVID-19 through contact with Resident #7. Observation outside Resident #8's room on 8/26/2021 at 10:30 AM, 8/27/2021 at 11:00 AM, and 8/28/2021 at 11:28 AM, revealed no sign on the door and no isolation cart. Review of the medical record, revealed Resident #9 was admitted to the facility on [DATE] with diagnoses of Cerebrovascular Accident, Hemiparesis, Hemiplegia, Depression, and Hypertension. Review of a Test Result dated 8/19/2021, revealed Resident #9 tested positive for COVID-19. Review of the medical record, revealed Resident #10 was admitted to the facility on [DATE] with diagnoses of Diabetes Mellitus, Aphasia, Hyperlipidemia, Hypertension, and Cerebral Infarction. Review of a Midnight Census Report dated 8/19/2021, revealed Resident #9 and Resident #10 were roommates, and Resident #10 was exposed to COVID-19 by Resident #9. Observation outside Resident #10's room on 8/26/2021 at 10:32 AM, 8/27/2021 at 11:02 AM, and 8/28/2021 at 11:30 AM, revealed no sign on the door and no isolation cart. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445331	A. Building B. Wing	08/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Graceland Rehabilitation and Nursing Care Center	1250 Farrow Road Memphis, TN 38116

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record, revealed Resident #11 was admitted to the facility on [DATE] with diagnoses of Emphysema, Prostate Cancer, Congestive Heart Failure, and Hypertension. Review of a Test Result dated 8/19/2021, revealed Resident #11 tested positive for COVID-19. Review of the medical record, revealed Resident #12 was admitted to the facility on [DATE] with diagnoses of Dementia, Chronic Obstructive Pulmonary Disease, Hyperlipidemia, Anxiety, Alzheimer's Disease, and Hypertension. Review of a Midnight Census Report dated 8/19/2021, revealed Resident #11 and Resident #12 were roommates, and Resident #12 was exposed to COVID-19 through contact with Resident #11. Observation outside of Resident #12's room on 8/26/2021 at 10:34 AM, 8/27/2021 at 11:04 AM, and 8/28/2021 at 11:35 AM, revealed no sign on the door and no isolation cart. Review of the medical record, revealed Resident #13 was admitted to the facility on [DATE] with diagnoses of Psychosis, Dementia, Congestive Heart Failure, Hypertension, Cerebral Infarction, and End Stage Renal Disease. Review of a Test Result dated 8/19/2021, revealed Resident #13 tested positive for COVID-19. Review of the medical record, revealed Resident #14 was admitted to the facility on [DATE] with diagnoses of Hemiplegia, Hemiparesis, Diabetes Mellitus, Schizophrenia, and Hypertension. Review of a Midnight Census Report dated 8/19/2021, revealed Resident #13 and Resident #14 were roommates, and Resident #14 was exposed to COVID-19 by Resident #13. Observation outside Resident #14's room on 8/26/2021 at 10:36 AM, 8/27/2021 at 11:07 AM, and 8/28/2021 at 11:38 AM, revealed no sign on the door and no isolation cart. During an interview on 8/28/2021 at 11:30 AM, outside Resident #14's room, Housekeeper #1 stated, . nothing says they are in isolation, they don't have a sign or a cart . During an interview on 8/28/2021 at 12:18 PM, the Director of Nursing (DON) stated, I'm just being honest with you .they [Resident #7, #9, #11, and #13] tested positive on Friday [8/20/2021] .the nurse didn't tell the Unit Manager, so they didn't get put in isolation for COVID exposure . During an interview on 8/27/2021 at 11:25 AM, the Infection Control Preventionist confirmed that Residents #8, #10, #12, and #14 had been exposed to COVID-19 when their roommates tested positive, and they should have been in isolation with a sign on the door and a cart outside their room. She stated, I don't know why there's not a cart or sign . Review of the Staff Time Punch Reports and COVID-19 Daily Employee Screening Logs from 8/9/2021-8/23/2021, revealed the following employees worked on the following days and failed to screen for signs and symptoms of COVID-19: a. Housekeeper #2 - 8/11/2021 and 8/12/2021 (continued on next page)

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	445331	A. Building B. Wing	08/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Graceland Rehabilitation and Nursing Care Center	1250 Farrow Road Memphis, TN 38116

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Housekeeper #3 - 8/14/2021, 8/19/2021, and 8/22/2021 During an interview on 8/30/2021 at 2:00 PM, the Business Office Staff member was asked if Housekeeper #2 and Housekeeper #3 had screened for COVID-19 prior to working in the facility. She stated, .it's not documented they screened.