STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445431	A. Building B. Wing	10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ahc Lexington	727 East Church Street Lexington, TN 38351

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 30974 Based on policy review, Timeanddateweather.com review, medical record review, observation, and interview, the facility failed to ensure a safe, secure environment for a vulnerable cognitive impaired resident for 1 of 3 (Resident #60) sampled residents reviewed for elopement. The facility's failure to ensure a safe, secure environment resulted in Immediate Jeopardy when on 8/27/2023, Resident #60 exited the facility through an unsecured door, unsupervised. Resident #60 was brought back to the facility by a unknown civilian who stated Resident #60 was found on a busy 4 lane highway, in a self-propelled wheelchair at a [Named Bank] approximately 0.19 of a mile from the facility. The temperature was 91 degrees. Resident #60 was last seen in the facility on 8/27/2023 at approximately 4:20 PM, and was brought back to the facility between approximately 4:36PM and 4:38 PM. The facility was not aware the resident was missing until he was brought back to the facility. 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 and impairment or death to a resident. The Administrator, the Director of Nursing (DON), the Regional Director of Nurse Consultant, and the Assistance Director of Nursing (ADON) were notified of the Immediate Jeopardy for F-689 on 9/29/2023 at 6:15 PM, in the Conference Room. The facility was cited Immediate Jeopardy at F-689. The facility was cited F-689 at a scope and severity of J, which is Substandard Quality of Care. The IJ existed from 8/27/2023 through 10/4/2023. The Immediate Jeopardy was removed onsite when the facility implemented a corrective action plan. The corrective actions were validated onsite by the surveyors on 10/4/2023. The IJ was cited at F-689 and the facility is required to submit a Plan of Correction. The findings include: (continued on next page)

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

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Review of the facility's policy titled, Elopements and Wandering Patients, revised 6/21/2022, revealed . Purpose: This facility ensures that residents who exhibit wandering behavior .receive adequate supervision . Wandering is a random or repetitive locomotion that may be goal directed .(e.g. the person appears to be searching for something such as an exit) or non-goal or aimless .Elopement occurs when a resident leaves the premise or a safe area without authorization .and/or necessary supervision to do so . Review of the facility's policy titled, Resident Rights and Resident Responsibilities, revised 1/2022, revealed . the resident has a right to a safe .environment . Review of the facility's policy titled, Accidents and Supervision, revised 10/21/2021, revealed .resident environment remains as free of accidents as is possible; and each resident receives adequate supervision . to prevent accidents .identify hazard (s) and risk (s) .definition .any unexpected or unintentional incident .risk . characteristic of an individual resident that influences the likelihood of an accident .adequate supervision refers to interventions and means of mitigating risk of an accident .the facility will provide adequate supervision to prevent accidents . 2. Medical record review revealed Resident #60 was admitted to the facility on [DATE], with diagnoses of Dementia, Diabetes, Anxiety Disorder, Unsteadiness on Feet, Muscle weakness, Heart Disease, Benign Prostatic Hyperplasia and Hypertension. Review of the annual Minimum Data Set (MDS) dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of 9, which indicated Resident #60 had moderate cognitive impairment. Further review revealed Resident #60 had impaired vision with corrective lenses. Resident #60 required extensive assistance with mobility, transfers, dressing, toileting, and personal hygiene and uses a walker and wheelchair for mobility. There was no documentation in the MDS assessment of the resident exhibiting wandering or exit seeking behaviors. Review of the care plan date 8/11/2023 documented .at risk for confusion /alteration in thought process related to dementia with interventions .orientation and re-direction as needed when exhibiting anxiety . Resident #60 has a diagnosis of Anxiety Disorders manifested by Verbal Distress and physical manifestations of anxiety with interventions. Continued review of the care plan revealed .Assess and record behaviors .Assess the need for PRN [as needed] antianxiety medications if interventions do not relieve anxiety .Conduct 1:1 visits .Observe for changes in behavior, altered mental status, sudden change in cognitive function, orientation, and/or communication. Resident #60 has short term memory impairment with interventions .to use cues to enhance participation in self-care .provide quiet atmosphere with one on one support during periods of increased anxiety . Resident #60 is a risk for falls related to muscle weakness and unsteadiness on feet, decrease functional abilities, impulsivity related to dementia with interventions .nonskid strips to floor .apply raised edge mattress .locomotes using feet remove foot pedals from wheelchair . footwear to have nonskid soles . Continued review of the care plan revealed Resident #60 was not care planned for elopement/wandering. (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 Physical Therapy PT Evaluation & [and] Plan of Treatment with dates of service dated 8/2/2023 - 8/31/2023, revealed .start of care 8/4/2023 . Assessment Summary .Reason for Therapy .Clinical Impressions .patient presents with strength impairments and decreased dynamic balance, decreased static balance, decreased function capacity, decrease insight and decreased safety awareness .Complexities . exacerbation of cognitive impairment .Dates of Service 8/2/2023-8/31/2023 .Pt. [patient] cont's [continues] to have minimal unsteadiness and safety deficits resulting in supervision gait with much of the unsteadiness resulting from turning quickly and not completing thoughtful processing of task at hand such as turning corners, turning around to sit, looking side to side when walking in the halls . Review of the facility's Event Note dated 8/27/2023, revealed .civilian came to nursing home and asked did we know [Resident #60]. Reported that he [Resident #60] was in truck. Resident in front seat of truck. Civilian reported she found resident in front of [Named Bank] .STEPS INPLEMENTED TO PREVENT RECURRENCE: Place wander guard on resident ankle . Review of the website Timeanddateweather.com revealed temperature for Lexington, Tennessee on Sunday August 27, 2023, at 4:15 PM, through 4:55 PM, ranged from 82 - 84 degrees Fahrenheit and was cloudy. Care plan updated 8/27/2023, documented .Resident #60 has exhibited Wandering Behavior .elopement from facility .wander guard placed .interventions .ensure all door alarms/locks are armed to reduce the risk of leaving secure areas .assess potential cause for wandering (the need for food and water) .Redirect when wandering .monitor resident's location to ensure safety .use wander guard/location monitor daily . Review of the facility's Clinical Note dated 8/28/2023 at 4:20 AM, revealed .Resident on 15-minute checks with wander guard in place .observed ambulating down hallway resident redirected back to room . Review of the facility's Clinical Note dated 8/28/2023 at 11:15 AM, revealed .Patient noted to have no recollection of leaving or attempting to leave facility. Patient stated, Did I try to go somewhere yesterday . BIMS score as of today is an 8 . Review of the facility's Logbook Documentation Technology Enhanced Learning in Science (TELS) report dated 8/28/2023, revealed .Location .front door Fail .mag lock messed up on door . Review of an invoice dated 8/28/2023, revealed .service call 8/28/23 to diagnose front door egress issue [locking mechanism that opens and closes] .inspected door situation .Wires were not properly connecting to panel .able to allow egress to work until parts arrive to fix eight issues .Service call 8/29/23 .door is messing up again .waiting on parts to properly fix door .return visit on 8/31/23 to fix door .9/12/2023 .adjusted door closer on front main entry . Review of the facility's Logbook Documentation Technology Enhanced Learning in Science report revealed 9/12/2023, .Location .front door Fail .not working sometimes . Observation on 9/25/2023 at 12:00 PM, revealed Resident #60 in their room, sitting in wheelchair, talking with daughter. Resident #60 is alert with confusion unable to recall incident when he exited the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 10/4/2023 at 3:05 PM, revealed the Maintenance Director measured the distance from front door entrance threshold to edge of facility's entrance driveway, which was 176 feet and 8 inches. Observations on 10/4/2023 at 3:08 PM, revealed a busy 4 lane highway with a turning lane and a paved shoulder, with continuous flow of heavy traffic. Speed limit signage posted in front of facility 40 miles per hour (MPH). A Car Lot Business is located next to the facility and a Car Lot Business across the street from the facility. The [Named Bank] is located approximately 0.19 miles from the facility. No sidewalk is present next to highway. During an interview on 9/25/2023 at 12:00 PM, Resident #60's daughter stated on 8/27/2023, .had taken him out for his birthday .brought him back to the facility around 12:00 PM .the facility called me around 5:00 PM and said that my dad had gotten out of the facility .told me he propelled himself out of the parking lot, went to the right, went up the hill and down the hill to the bank .a man and a woman in a truck noticed him half on the road and shoulder of the road in his wheelchair, so they boxed him in [he was drifting toward the road], to prevent him from going further, got in front of him at the [Named Bank] branch down the street .they asked him where he was going .he [Resident #60] told them he was going to [Named Restaurant] to get something to eat .that restaurant has been closed for years and thank God cause he would have crossed that busy highway to get to that building .when we returned to the building from eating lunch he was good .did not mention anything about going home .staff said the woman and man that brought him back said they asked him where he came from and he told them the hospital [that's what he calls the nursing home] .they put him [Resident #60] and his wheelchair in the truck and brought him back to the nursing home .rang the doorbell and when staff opened the door they [man and woman] asked if they were missing anyone .They [staff] didn't even know he was gone .thankful he didn't get hurt .he was in therapy because he is very unsteady .they want him to use the wheelchair instead of getting up trying to walk .they didn't know who had let him out, or how he got out .staff will use the remote door opener to let people in and out of the front entrance door and do not make sure or take the time to watch who is going out or coming in .at times I will come and they will open the door [with the] remote and I never see any staff in the lobby or nurses station .but no one is at the door putting in the code . During an interview on 9/26/2023 at 9:03 AM, the Maintenance Director stated, .[Name of License Practical Nurse (LPN) #2] notified me [on 8/27/2023 prior to Resident #60's elopement] that there was a problem with the front entrance door not locking .told her I could not come right away .I was not near the facility it was on a Sunday .before I could get to the facility the Administrator called and said someone had gotten out and I needed to come and check the doors .been having problems with the front entrance door magnetic lock .not catching .not locking .that evening I adjusted the door to make sure it was catching when it closed .It malfunctioned again on 9/11/2023 got it inspected again and repaired .door checks are done weekly . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/26/2023 at 9:27 AM, LPN #2 stated on 8/27/2023, .[Resident #60] was confused and had been up around desk [prior to the resident's elopement] .heard him say he wanted to go back to his room .a little while after a lady rung doorbell .I opened the door and the lady asked if we knew [Named Resident #60], we said yes and asked why, the lady said he was in the truck .the lady stated that she and her husband picked [Named Resident #60] up .he was rolling off the shoulder of the road in his wheelchair by [Named Bank] .we immediately assisted him out of the truck and back in the building .did not get the civilians names .I asked where he was picked him up .[Named Resident #60] did not recall anything about how he got out .when asked [Named Resident #60] how he got out he said a lady let him out .then he said he just went out the door he said he pushed on it .the front entrance door was malfunctioning .the door would not close and would not lock .the key pad was showing red [meaning locked and armed] like it was locked . people were coming in and out because it was not locking .at 1:18 PM, I called the Maintenance Director and reported the front entrance door was messing up .he told me he was not in town and could not come right away it would be a while .I should have called the on call and someone should have been monitoring the door .No one was assigned to the front entrance door until after he [Resident #60] got back .can't say who or if anyone let him out .don't know how long he was gone .the door should not have been unattended because it was not working properly .we should have put someone there to watch it .we didn't know he was gone until he was brought back .I did not get the lady's name or any information when he returned .me and Registered Nurse (RN) #2 was at the desk when the lady rang the doorbell and asked if we knew [Named Resident #60] . During an telephone interview on 9/26/2023 at 4:57 PM, LPN #3 stated on 8/27/202, .was working the 300 hall .I went to help his [Resident #60's] nurse [RN #1] she needed some help .I was told a couple had brought [Named Resident #60] back to the facility .LPN #2 told me the front entrance door was messed up [not closing or alarming] earlier during in the shift before he got out .saw [Named Resident #60] sitting in the hall near the nurses' station by the front lobby earlier .when he returned, he said he got out the building by putting his hand on the door and he pushing on it .he said it was hard going up the hill [in front of the facility] . During an interview on 9/27/2023 at 9:26 AM, the Physical Therapy Director stated, . [Named Resident #60] was evaluated on 8/4/2023 .uses the wheelchair independently propels self with legs and upper body .very unsteady during ambulation .impulsive .need redirection and cueing .must remind him with safety cues .short attention span .he would not be safe in a wheelchair propelling self on the road . During an interview on 9/27/2023 at 11:00 AM, RN #1 stated on 8/27/2023, .[Named Resident #60] was very confused asking me when he was going to leave .had went out with his family around 11:00 AM for his birthday and brought back about 12 [Noon] .[Named Resident #60] came up to the desk asking when he was going out .we were not able to redirect him .asked him if he wanted to go back to his room he stated yes .the aide took him to his room to watch TV, it was around 1-2 [PM] I think, really not sure .I was attending to something else when they told me somebody had brought him [Resident #60] back to the facility with his wheelchair in the back of the truck and wanted to know if he belonged to us .last I recall he was in his wheelchair in the entry hall .at 4:00 PM .the front entrance door was not working correctly .[LPN #2] called the Maintenance Director .he did not come right away .we should have been monitoring the front entrance door since it was broken .[Named Resident #60] told me he went out the door [front entrance door] with someone he don't know .I didn't know he was gone until he was brought back .when he got back we put a wanderguard on and his family came and stayed with him for a while .then we just monitored him frequently . he was not 1:1 observation . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/27/2023 at 11:20 PM, CNA #7 stated on 8/27/2023, .[Named Resident #60] went out to eat with his daughter for his birthday .that afternoon he started to get very confused, saying he wanted to go home .he was up walking .he is not steady and is usually in a wheelchair .he became agitated when I tried to redirect him .I told the nurse he was up walking and confused .around 4:00 PM the nurse told me to take him to his room .I took him to his room, he very became agitated .I had to do smoke break .while going out with the smokers I saw him from the end of the hall .he had come out of his room and was in the area around the nurses station sitting in his wheelchair by the lobby .it was around 4:20 PM .while outside I heard code green [code for missing resident] .I brought the smokers back in the building immediately .it was around 4:40 PM .we were outside about 10 minutes .once we got back in, found out [Named Resident #60] had been out of the building and brought back by some people .I kept an eye on him but not continuously . During an interview on 9/27/2023 at 4:00 PM, the Housekeeping Supervisor stated, .a friend called and said they were driving pass the nursing home and saw someone put a wheelchair and person in a truck down the street from the facility and thought it could have been a resident .I live close by I immediately headed to the facility. I called the Administrator and she told me there had been an elopement .I help the Maintenance Director when he is out .I was not notified that day to come about the door malfunctioning . During a telephone interview on 9/28/2023 at 9:48 AM, Regional Maintenance Director stated, .I knew about the front entrance door malfunctioning on 8/27 and a repair company came to fix it, not sure when it was fixed .I was notified this month on 9/12 door mag lock on the front entrance door was not working or making good contact and another company came out to fix it . During an interview on 9/29/2023 at 9:58 AM, the Nurse Practitioner (NP) stated, .I was made aware of the elopement, and he was found down the street at the bank. Someone found him and brought him back to the facility .assessed him [Named Resident #60] the next day .he has confusion .not safe for [Named Resident #60] to be out on that busy highway unsupervised . During an interview on 9/29/2023 at 10:48 AM, the Director of Nursing (DON) stated, .when the Maintenance Director told LPN #2, he could not come right away, LPN #2 should have contacted the on call supervisor and the Administrator. Someone should have been monitoring the door when it was noticed not working properly .everyone is responsible for the safety of the residents . [Named Resident #60] was always confused .BIMS is low, it was the perfect storm .the door being broken and someone let him out .or how he got out .it was definitely not a safe place for him, near the highway in his wheelchair . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/29/2023 at 12:06 PM, the Administrator stated, .I was informed on 8/27/2023 between 4:36 PM or 4:38 PM by [LPN #2] [Named Resident #60] was picked up at the bank and brought back to the facility by a Samaritan .I was not told about the malfunctioning of the front entrance door until he was back at the facility .[Named Resident #60] told the nurses a young lady held the door open for him .we can't confirm how he got out .on 8/28 the door company came out .parts were ordered .the door was repaired on 8/31 .the front entrance door malfunctioned again on 9/11 .it was fixed the next day .I should have been told about the malfunctioning front door when it was noticed .staff did not obtain the names of the Samaritans who brought him back .the staff should have identified them .I only got statements from the staff involved with the elopement not everyone . It was not a safe area for [Named Resident #60] to be out unsupervised .only the shoulder of the road, no sidewalk .very busy road and people usually don't do the speed limit .the DON and PT Director mimic the distance by putting self in wheelchair propelling with feet to the bank .it's a short distance less than 2 blocks from the facility .can't be sure how he left or when he left. [He] Was gone a short time but should not exit the facility without staff notice . During an interview on 10/2/2023 at 5:22 PM, the Medical Director stated .I saw him after the elopement, a couple days after .He was pleasantly confused, he has dementia and confusion is to be expected .I was notified the day he eloped it was on a Sunday .he did not have a wander guard on at that time till Sunday . [Named Resident #60] would not be considered safe to be outside unsupervised definitely not safe alone on that busy highway .he has dementia it would not be safe . In summation, the series of events leading up to Resident #60's elopement revealed the front entrance door of the facility was noted to be malfunctioning at approximately 1:30 PM, by a staff member. The front entrance door was not monitored for the malfunction. Resident #60 was found west of the facility on a busy 4 lane highway in a wheelchair by unknown civilians and returned to the facility. The distance measured from the front entrance door threshold to the end of the facility's driveway is 174 feet and 8 inches. The distance measured from the facility's driveway to the [Named Bank] is approximately 1034.10 feet (0.19 of a mile). Resident #60 was last seen by a staff member standing at the end of the hall seated in a wheelchair next to the lobby at 4:20 PM. Resident #60 was brought back to facility between 4:36 PM and 4:38 PM when staff made the Administrator aware. The facility's IJ Removal Plan was validated onsite by the surveyors on 10/4/2023 through policy review, observation, review of documents, review of education, sign in sheets, and administration and staff interview for the following: 1. The facility will ensure cognitively impaired residents receive adequate supervision to ensure a safe and secure environment and from exiting the facility unsupervised and without staff knowledge. The facility will take immediate action to provide a safe and secure environment, and to provide adequate supervision for all residents to prevent elopements. The facility will ensure staff are knowledgeable and competent to implement immediate actions for a malfunctioning door in order to protect residents from exiting the facility into an unsafe environment. Validated by the surveyors on site on 10/4/2023 by review of door checks documentation and observation, interview with the maintenance director and door vendors, review of the elopement book, elopement assessments and review of staff education. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An elopement drill was initiated by Nurse Management on 8/27/2023 on second shift. Elopement drills will take place on each shift for one week, twice a week for two weeks. If concerns are identified, the information will be communicated to the IDT and drills will continue until substantial compliance is achieved. If no concerns are identified at the end of two weeks, the information will be communicated to the IDT and facility will return to the previous auditing schedule. An elopement drill was completed by Nurse Management on 9/29/2023 on first shift. Validated onsite by surveyor on 10/4/2023 through interview with staff and door vendor, observation of front door entrance, review of door audits, elopement drills and staff education.