STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465006	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Olympus Rehabilitation Center	2200 East 3300 South Salt Lake City, UT 84109

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48709 Based on interview and record review, it was determined for 1 of 38 sampled residents, that the facility did not notify a representative of the Office of the State Long-Term Care Ombudsman of the transfer or discharge and the reasons for the move in writing. Specifically, when a resident was discharged to the hospital, the Ombudsman was not notified. Resident identifier: 21. Findings include: Resident 21 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included peripheral vascular disease, chronic obstructive pulmonary failure, type 2 diabetes mellitus with diabetic neuropathy, left and right leg above knee amputation, adjustment disorder with mixed anxiety and depressed mood, and hypertension. Resident 21's medical record was reviewed on 5/6/24 through 5/9/24. The medical record revealed resident 21 was discharged to the hospital for a change in condition on 2/18/24. Resident 21 was readmitted to the facility on [DATE]. A Hospital Progress Note dated 2/18/24 at 10:07 AM, indicated resident was admitted for Acute Hypoxic Respiratory Failure. On 5/8/24 at 2:31 PM, an interview was conducted with the Resident Advocate (RA). The RA stated that the facility did not notify the Ombudsman when resident 21 was admitted to the hospital in February. The RA further stated that she was not aware that she needed to inform the Ombudsman when a resident was transferred to the hospital or discharged from the facility, and had not been doing so.

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44640 Based on interviews and record review, the facility did not develop and implement a baseline care plan for 2 of 38 sample residents that included the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care, and be developed within 48 hours of the resident's admission. Specifically, a care plan was initiated 7 days after admission for two residents. Resident identifiers: 55 and 167. Findings include: 1. Resident 55 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Parkinson's disease with dyskinesia, dysphagia, difficulty walking, reduced mobility, repeated falls, dementia, visual hallucinations, major depressive disorder and neuromuscular dysfunction of the bladder. Resident 55's medical record was reviewed on 5/6/24. The care plans developed for resident 55 were reviewed. The 48 hour care plan was not developed until 2/15/24, this was 7 days after admission. 2. Resident 167 was admitted to the facility on [DATE] with diagnoses which included right hip osteoarthritis, chronic lymphocytic leukemia of b-cell type, morbid obesity, type II diabetes, chronic obstructive pulmonary disease, muscle weakness and hypertension. Resident 167's medical record was reviewed on 5/6/24. The care plans developed for resident 167 were reviewed. The 48 hour care plan was not developed until 4/30/24, this was 7 days after admission. On 5/09/24 at 9:23 AM, an interview was conducted with the Director of Nursing (DON). The DON stated when a resident was admitted there is an assessment that should be done by the admitting nurse that would populate the baseline care plan. The DON stated after a week the Minimum Data Set (MDS) coordinator would do the comprehensive care plan. The DON stated if the resident did not have that admission assessment completed then it would not populate the baseline care plan. The DON stated the nursing administration were in charge of making sure the base line care plans were completed. The DON stated there was not an admission assessment completed for either resident 55 or 167 so neither had a baseline care plan 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on interview and record review, the facility did not ensure that care plans for 2 of 38 sample residents were developed within 7 days after the completion of the comprehensive assessment, or revised by the interdisciplinary team after each assessment. Resident identifiers: 121 and 127. Findings include: 1. Resident 121 was admitted to the facility on [DATE] with diagnoses that included traumatic brain injury, vascular dementia, traumatic brain hemorrhage, cognitive communication deficit, and anxiety disorder. Resident 121's medical record was reviewed from 5/6/24 through 5/9/24. On 9/11/23, resident resident 121's BIMS on the Admission MDS assessment was an 8, indicating moderate cognitive impairment. The MDS also indicated the the resident had wandered 1 to 3 days in the look back period. The MDS triggered behaviors on the Care Area Assessment Summary, however no wandering care plan was developed until 9/29/23. It should be noted that this was after the resident had eloped multiple times. Resident 121's care plan was reviewed. A care plan dated 9/29/23 indicated that the resident was an elopement risk/wanderer that eloped on 9/29/23 r/t (related to) Impaired safety awareness, Resident wanders aimlessly, resident wanting to just get out of here. A Wandering Risk Scale quarterly assessment for resident 121 was completed on 9/4/23. The assessment indicated that resident 121 was at a low risk to wander. Resident 121's progress notes were reviewed and revealed the following: a. On 9/10/23, Very restless and agitated today. Redirected and reoriented frequently paranoid. Exited facility 2 times today and brought back. The nurses note did not give additional details about the 2 elopements from the facility that were referenced. b. On 9/23/23 at 8:52 AM, Very agitated and restless difficult to redirect. Attempting to walk to road. c. On 9/23/23 at 2:58 PM, LCSW (Licensed Clinical Social Worker) provided emotional support. He was tearful . reports feelings of uncertainty with not being able to leave the building. d. On 9/23/23 at 2:58 PM, Continues to wander. e. On 9/23/23 at 4:19 PM, Displays paranoia startles easily. Becomes agitated when people invade his personal space. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. On 9/23/23 at 10:18 PM, Resident continued agitated and exit-seeking behavior. This Nurse needed to run out to stop Resident from either trying to get on bus at bus stop in front of facility, and then to stop him from heading east on sidewalk, on two separate incidents. Resident has been checked on frequently by Nurse and by CNA staff. Staff acted to dissuade him from entering Lobby or trying to leave building via front door. Resident set off alarms at more than one of the other doors, press on on bar but not know the code. g. On 9/29/23 at 7:39 PM, At [5:15 PM] resident was not in his room to receive his dinner. floor nurse and CNA's, initiated Building check. Resident was last seen at [4:45 PM] by the lobby. Resident was not located after the building wide check.Floor nurse received call at [5:45 PM] from paramedics resident was found a few blocks from facility, no injuries noted. Resident was agitated . performing 15 minute checks. h. On 9/30/34 at 12:02 AM, Resident continued to attempt to leave numerous times until resident agreed to let the CNAs get him in bed . i. On 10/3/23, Resident continues on one on one supervision for behaviors. Resident restless and impulsive. On 9/29/23, the facility submitted a form 358 to the State Survey Agency, indicating that the resident had eloped at 4:50 PM, and was found outside the facility by a concerned citizen. On 5/8/24 at 10:36 AM, an interview was conducted with the RA. The RA stated that resident 121 had repeatedly removed his wanderguard, and that he had broken at least three. The RA stated that there was not order for resident 121 to have a wanderguard. [Note: No physician's order or assessment for the resident's wanderguard was located in the resident's medical record, even though staff had placed a wanderguard on the resident per documentation in the progress notes.] No information could be located in resident 121's medical record to indicate other interventions the facility had implemented in order to prevent the resident from eloping, after the resident was able to remove his wanderguard. On 5/9/24 at 9:45 AM, an interview was conducted with the facility DON. The DON stated that she remembered that resident 121 had been placed on one on one a few times but was unable to describe other interventions that had been put into place to prevent resident 121 from eloping again. 2. Resident 127 was admitted on [DATE] with diagnoses that included heart failure, palliative care, senile degeneration of brain, degenerative disease of nervous system, dementia, major depressive disorder, bipolar, and anxiety. Resident 127's medical record was reviewed from 5/6/24 through 5/9/24. On an annual MDS assessment dated [DATE], staff indicated that resident 127's BIMS was unable to be determined because the resident was severely cognitively impaired. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/11/22, a care plan was developed that indicated resident 127 is a wanderer r/t (related to) History of attempts to leave facility unattended, Impaired safety awareness. [Note: The care plan had not been updated since 10/11/22, even though resident 127 had eloped or attempted to elope multiple times after that.] On 2/10/23, resident 127's wander risk assessment indicated that the resident was a high risk to wander, due to poor safety awareness and cognition as well as a history of wandering the facility. The assessment also indicated that the resident was unsafe for independent community visits. Resident 127's progress notes were reviewed and indicated the following: a. On 4/14/23, Pt confused at times. Tries to wander out of building, wander guard on and working . b. On 5/16/23 at 4:05 PM, Res (resident) Was very anxious today and trying to escape. c. On 5/16/23 at 5:00 PM, Res had been trying to leave the building all day. As the day went on he was getting more nervous and agitated. I administered scheduled doses of lorazepam and called Hospice to get PRN lorazepam ordered as well. Offered several different ways to help Rescalm (sic) down in addition to PRN anti-anxiety medications including calling family, watching TV, eating snacks, listening to music, walking with resident. Res had Wander guard on and it was working throughout the day when he would approach a door. Around 1700 (5:00 PM) I moved Res to the dining area so that he could be occupied by eating dinner. I left as the kitchen staff were setting a place for him. not too much longer, around 1730 (5:30 PM) the police arrived the [resident 127] sic saying they had found him around 2700 E. Talking with nursing staff, Wander guard alarm was not heard. Administered additional PRN dose of Ativan and helped res settle in bed. Preformed (sic) skin check and found no new open areas. Advised Nursing staff to keep a very close eye on him andto (sic) monitor if his wander guard is working appropriately next time he gets up. Res was tired and quick to fall to sleep once returning to facility. On the facility submitted a form 359 to the State Survey Agency regarding the incident on 5/16/23. The facility determined that the front doors were malfunctioning [name of company] is repairing and servicing door on 5/24/23. d. On 6/12/23, Pleasant, mostly cooperative. Wander-Guard D/T (due to) exit-seeking behavior during the daytime into the early evening.Resident sleeping restfully at present, but attempted to go out the front door x2 early in the shift, and was stopped by staff and wanderguard device. e. On 7/16/23, Resident is alert and oriented x 1, is able to follow some of simple command (sic) at times, mood is stable, had episode of exit seeking, stopt (sic) by set off alarm of the door by a wander guard which is placed on his ankle, refused to eat breakfast at times, ate lunch and dinner, ate double tray at times. Resident has pain to knees, worse on right knee currently, has difficult time to walk. Staffs (sic) encouraged resident to use w/c (wheelchair) and call for help to assist him to use toilet, but resident is unableto (sic) redirect, had an episode of setting on the floor when was walking self to use toilet noted . (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. On 8/17/23, Resident is alert and oriented x 1, is able to follow some of simple command (sic) at times, mood is stable, had episode of exit seeking, stop by set off alarm (sic) of the door by a wander guard which is placed on his ankle . [Note: No physician's order or assessment for the resident's wanderguard was located in the resident's medical record, even though staff had placed a wanderguard on the resident per documentation in the progress notes.] No information could be located in resident 127's medical record to indicate other interventions the facility had implemented in order to prevent the resident from eloping. On 5/9/24 at 9:45 AM, an interview was conducted with the Director of Nursing (DON). The DON confirmed that the care plans for residents 121 and 127 had not been developed and/or revised in a timely manner. [Cross refer to F689]

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 22992 Based on interview and record review, the facility did not ensure that 4 of 38 sample residents were provided adequate supervision and assistance devices to prevent accidents. Specifically, residents had a wanderguard placed without a physician order or assessment. In addition, residents were able to elope from the facility multiple times without additional interventions put into place. Resident identifiers: 120, 121, 125, and 127. Findings include: 1. Resident 120 was admitted to the facility on [DATE] with diagnoses that included traumatic brain injury, memory deficit, schizophrenia, psychosis, Addison's disease, and diabetes mellitus. Resident 120's medical record was reviewed from 5/6/24 through 5/9/24. On 10/6/24, resident 120's Brief Interview for Mental Status (BIMS) on the Minimum Data Set (MDS) assessment was an 8, indicating moderate cognitive impairment. Resident 120's care plan was reviewed. A care plan dated 10/7/23 indicated that the resident was at risk for impaired safety related to Wandering. HE HAS IMPAIRED INSIGHT. A Wandering Risk Scale quarterly assessment for resident 120 was completed on 10/6/23. The assessment indicated that resident 120 could not follow instructions, and was at a high risk to wander. Resident 120's progress notes were reviewed and revealed the following: a. On 10/29/23, pt (patient) agitated. wanted wander guard off, says he was told he only had to wear it for a couple of days. arguing with staff. Quieter after meds (medications) taken and pt had a slice of pizza. b. On 11/1/23 at 12:26 AM, At change of shift (approx (approximately) [6:00 PM]) nurses informed Resident was outside (wanderguard removed by resident) and attempting to climb over fence in rear of the premises. CNA (Certified Nursing Assistant) had also informed ADON (Assistant Director of Nursing) who contacted Nurse while he was responding to the situation. Nurse and Guardian . spoke with Resident at length, attempting to convince him to come inside. Resident told Guardian he might rather be injail (sic) . However, he decided to return inside with staff. PRN (as needed) Ativan prepared, but Resident did not want to accept shot. c. On 11/1/23 at 6:50 AM, At approximately [5:40 AM] Resident was noted missing. He was last seen just before that time. Nurse organized a search, both inside and outside the building. On search, noted that part of the rear fence was broken out. [Note: No physician's order or assessment for the resident's wanderguard was located in the resident's medical record, even though staff had placed a wanderguard on the resident per documentation in the progress notes.] (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/9/24 at 9:45 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 120 had a wanderguard placed but he took it off repeatedly. The DON stated that resident 120 was delusional about the reasons a wanderguard had been placed on him. The DON stated that she was unsure if there was a specific wanderguard assessment, and that there should be a physician's order for a wanderguard to be placed on a resident. The DON stated that resident 120's guardian wanted the wanderguard placed, so facility staff followed the guardian's wishes. The DON stated that after the first time resident 120 left the facility, she was unsure if the wanderguard was placed on the resident again. The DON stated that after the resident left the faciity on [DATE] the second time, he was later located and taken to a different facility. The DON stated that if a resident repeatedly removed their wanderguard, staff would try a different intervention to ensure a resident's safety, however she was unsure if any other interventions were attempted for resident 120. The DON confirmed that resident 120 was on a one to one status with facility staff when he eloped from the facility on 11/1/23. The DON stated that on 11/1/23, the staff member, Certified Nursing Assistant (CNA) 1 left resident 120 to walk into the kitchen but came right back and the resident was gone. On 5/9/24 at 11:55 AM, an interview was conducted with CNA 1. CNA 1 stated that on 11/1/23 he was supposed to be with resident 120 on a one on one basis. CNA 1 stated that he entered the kitchen to get some ice water for another resident, closed the door, and left resident 120 by the door of the kitchen. CNA 1 stated that resident 120 was supposed to be standing next to the door of the kitchen. CNA 1 stated that when he opened the kitchen door to exit the kitchen, resident 120 was gone. CNA 1 stated that he had only closed the door for like 8 seconds. CNA 1 stated that resident 120's wanderguard was on at the time the resident eloped, because they had put it on because he kept trying to escape. CNA 1 stated that resident 120 had removed the wanderguard two or three times prior to 11/1/23. On 11/1/23, the facility submitted a form 358 to the State Survey Agency (SSA). The form documented that on 11/1/23 at 5:45 AM, a facility nurse went to check on resident 120 and was unable to locate him. On 11/2/2023 at 1:35 PM, a phone call was placed to the facility. A conversation was completed with the Resident Advocate (RA). The RA confirmed the Resident had not returned to the building but stated that they had received a phone call from him this morning requesting a ride back to the facility from the homeless shelter. When facility staff arrived at the shelter, the resident was gone. The facility gave the shelter and the police their contact information in case he returned so they could take him back to the facility. The RA stated that due to the Resident's health history, he was placed under guardianship. The RA stated that when the Resident was admitted , he did not want to stay. The RA stated the resident was doing well until his roommate had to go to the hospital. The facility staff and his guardian feel this triggered the resident and made him want to leave. The Resident was assessed as needing a wander guard upon admission but did not want to wear it and had taken it off multiple times and liked to trigger the door alarms. The RA confirmed the Resident did not have a wander guard in place when he eloped on 11/1/2023 because he took it off. The RA stated the guardian stated it was not uncommon for the resident to leave a facility, and he had a history of doing this but always showed back up. The RA stated that approximately three minutes before the resident eloped, an aide was with him walking the building because he was having trouble sleeping. The aide left the resident to get ice for another resident, and when he returned, the resident was gone. The RA stated staff immediately called administration and the police, who all began searching for the Resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident 121 was admitted to the facility on [DATE] with diagnoses that included traumatic brain injury, vascular dementia, traumatic brain hemorrhage, cognitive communication deficit, and anxiety disorder. Resident 121's medical record was reviewed from 5/6/24 through 5/9/24. On 9/11/23, resident resident 121's BIMS on the Admission MDS assessment was an 8, indicating moderate cognitive impairment. The MDS also indicated the the resident had wandered 1 to 3 days in the look back period. The MDS triggered behaviors on the Care Area Assessment Summary, however no wandering care plan was developed until 9/29/23. It should be noted that this was after the resident had eloped multiple times. Resident 121's care plan was reviewed. A care plan dated 9/29/23 indicated that the resident was an elopement risk/wanderer that eloped on 9/29/23 r/t (related to) Impaired safety awareness, Resident wanders aimlessly, resident wanting to just get out of here. A Wandering Risk Scale quarterly assessment for resident 121 was completed on 9/4/23. The assessment indicated that resident 121 was at a low risk to wander. Resident 121's progress notes were reviewed and revealed the following: a. On 9/10/23, Very restless and agitated today. Redirected and reoriented frequently paranoid. Exited facility 2 times today and brought back. The nurses note did not give additional details about the 2 elopements from the facility that were referenced. b. On 9/23/23 at 8:52 AM, Very agitated and restless difficult to redirect. Attempting to walk to road. c. On 9/23/23 at 2:58 PM, LCSW (Licensed Clinical Social Worker) provided emotional support. He was tearful . reports feelings of uncertainty with not being able to leave the building. d. On 9/23/23 at 2:58 PM, Continues to wander. e. On 9/23/23 at 4:19 PM, Displays paranoia startles easily. Becomes agitated when people invade his personal space. f. On 9/23/23 at 10:18 PM, Resident continued agitated and exit-seeking behavior. This Nurse needed to run out to stop Resident from either trying to get on bus at bus stop in front of facility, and then to stop him from heading east on sidewalk, on two separate incidents. Resident has been checked on frequently by Nurse and by CNA staff. Staff acted to dissuade him from entering Lobby or trying to leave building via front door. Resident set off alarms at more than one of the other doors, [NAME] on bar but not know the code. g. On 9/29/23 at 7:39 PM, At [5:15 PM] resident was not in his room to receive his dinner. floor nurse and CNA's, initiated Building check. Resident was last seen at [4:45 PM] by the lobby. Resident was not located after the building wide check.Floor nurse received call at [5:45 PM] from paramedics resident was found a few blocks from facility, no injuries noted. Resident was agitated . performing 15 minute checks. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	h. On 9/30/34 at 12:02 AM, Resident continued to attempt to leave numerous times until resident agreed to let the CNAs get him in bed . i. On 10/3/23, Resident continues on one on one supervision for behaviors. Resident restless and impulsive. On 9/29/23, the facility submitted a form 358 to the State Survey Agency, indicating that the resident had eloped at 4:50 PM, and was found outside the facility by a concerned citizen. On 5/8/24 at 10:36 AM, an interview was conducted with the RA. The RA stated that resident 121 had repeatedly removed his wanderguard, and that he had broken at least three. The RA stated that there was not order for resident 121 to have a wanderguard. [Note: No physician's order or assessment for the resident's wanderguard was located in the resident's medical record, even though staff had placed a wanderguard on the resident per documentation in the progress notes.] No information could be located in resident 121's medical record to indicate other interventions the facility had implemented in order to prevent the resident from eloping, after the resident was able to remove his wanderguard. On 5/9/24 at 9:45 AM, an interview was conducted with the facility DON. The DON stated that she remembered that resident 121 had been placed on one on one a few times but was unable to describe other interventions that had been put into place to prevent resident 121 from eloping again. 3. Resident 125 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, delusional disorder, pneumonia, severe protein calorie malnutrition, psychoactive substance abuse, and altered mental status. Resident 125's medical record was reviewed from 5/6/24 through 5/9/24. An MDS assessment dated [DATE] revealed the resident had a BIMS of 9, indicating moderate cognitive impairment. On 5/27/23, a wander risk assessment for resident 125 indicated that she was a low wander risk. On 5/28/23, a care plan was developed for resident 125 indicating that she was at risk for impaired safety related to Wandering. On 6/5/23, a wander risk assessment for resident 125 indicated that she was a high wander risk. Resident 125's progress notes were reviewed and revealed the following: a. On 5/31/23, resident 125 later escorted back into Mt. Olympus by [name of local transport company] guard, pt had gotten on the bus wanting to get to Seattle. Pt room close to nurse station, staff monitoring pt as closely as possible. (continued on next page)

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MT Olympus Rehabilitation Center	2200 East 3300 South Salt Lake City, UT 84109

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 - Minimal harm or potential for actual harm Residents Affected - Some	b. On 6/12/23 at 11:48 PM, Staff discovered Resident absent from the facility. The lat apparent time that she was seen was approximately an hour ago. Another Resident reported to staff that he had seen her crossing the street to bus stop. c. On 6/13/23, the resident returned from the hospital, and Wanderguard placed on right ankle and working . d. On 7/2/23, Day nurse (2 July 2023) reported Resident had removed wanderguard at some point. Resident has awakened and left her room from time to time, and staff are being watchful for attempts to leave. [Note: No physician's order or assessment for the resident's wanderguard was located in the resident's medical record, even though staff had placed a wanderguard on the resident per documentation in the progress notes.] No information could be located in resident 125's medical record to indicate other interventions the facility had implemented in order to prevent the resident from eloping, after the resident was able to remove her wanderguard. 4. Resident 127 was admitted on [DATE] with diagnoses that included heart failure, palliative care, senile degeneration of brain, degenerative disease of nervous system, dementia, major depressive disorder, bipolar, and anxiety. Resident 127's medical record was reviewed from 5/6/24 through 5/9/24. On an annual MDS assessment dated [DATE], staff indicated that resident 127's BIMS was unable to be determined because the resident was severely cognitively impaired. On 10/11/22, a care plan was developed that indicated resident 127 is a wanderer r/t (related to) History of attempts to leave facility unattended, Impaired safety awareness. [Note: The care plan had not been updated since 10/11/22, even though resident 127 had eloped or attempted to elope multiple times after that.] On 2/10/23, resident 127's wander risk assessment indicated that the resident was a high risk to wander, due to poor safety awareness and cognition as well as a history of wandering the facility. The assessment also indicated that the resident was unsafe for independent community visits. Resident 127's progress notes were reviewed and indicated the following: a. On 4/14/23, Pt confused at times. Tries to wander out of building, wander guard on and working . b. On 5/16/23 at 4:05 PM, Res (resident) Was very anxious today and trying to escape. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. On 5/16/23 at 5:00 PM, Res had been trying to leave the building all day. As the day went on he was getting more nervous and agitated. I administered scheduled doses of lorazepam and called Hospice to get PRN lorazepam ordered as well. Offered several different ways to help Rescalm (sic) down in addition to PRN anti-anxiety medications including calling family, watching TV, eating snacks, listening to music, walking with resident. Res had Wander guard on and it was working throughout the day when he would approach a door. Around 1700 (5:00 PM) I moved Res to the dining area so that he could be occupied by eating dinner. I left as the kitchen staff were setting a place for him. not too much longer, around 1730 (5:30 PM) the police arrived the [resident 127] sic saying they had found him around 2700 E. Talking with nursing staff, Wander guard alarm was not heard. Administered additional PRN dose of Ativan and helped res settle in bed. Preformed (sic) skin check and found no new open areas. Advised Nursing staff to keep a very close eye on him andto (sic) monitor if his wander guard is working appropriately next time he gets up. Res was tired and quick to fall to sleep once returning to facility. On the facility submitted a form 359 to the State Survey Agency regarding the incident on 5/16/23. The facility determined that the front doors were malfunctioning [name of company] is repairing and servicing door on 5/24/23. d. On 6/12/23, Pleasant, mostly cooperative. Wander-Guard D/T (due to) exit-seeking behavior during the daytime into the early evening.Resident sleeping restfully at present, but attempted to go out the front door x2 early in the shift, and was stopped by staff and wanderguard device. e. On 7/16/23, Resident is alert and oriented x 1, is able to follow some of simple command (sic) at times, mood is stable, had episode of exit seeking, stopt (sic) by set off alarm of the door by a wander guard which is placed on his ankle, refused to eat breakfast at times, ate lunch and dinner, ate double tray at times. Resident has pain to knees, worse on right knee currently, has difficult time to walk. Staffs (sic) encouraged resident to use w/c (wheelchair) and call for help to assist him to use toilet, but resident is unableto (sic) redirect, had an episode of setting on the floor when was walking self to use toilet noted . f. On 8/17/23, Resident is alert and oriented x 1, is able to follow some of simple command (sic) at times, mood is stable, had episode of exit seeking, stop by set off alarm (sic) of the door by a wander guard which is placed on his ankle . [Note: No physician's order or assessment for the resident's wanderguard was located in the resident's medical record, even though staff had placed a wanderguard on the resident per documentation in the progress notes.] No information could be located in resident 127's medical record to indicate other interventions the facility had implemented in order to prevent the resident from eloping. [Cross refer to F657]

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44640 Based on interview and record review it was determined, for 1 of 38 sampled residents, that the facility did not ensure that each resident's drug regimen was free from unnecessary drugs. An unnecessary drug was any drug when used in excessive dose; or for excessive duration; or without adequate monitoring; or without adequate indication for its use; or in the presence of adverse consequences which indicated that the dose should be reduced or discontinued. Specifically, a resident's blood pressure (B/P) medication was administered outside of physicians ordered parameters. Resident identifier: 4. Findings include: Resident 4 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Parkinson's disease with dyskinesia, traumatic subdural hemorrhage, severe protein calorie malnutrition, type II diabetes, dysphagia, chronic kidney disease stage 3, hypothyroidism, gastro-esophageal reflux disease and hypertension. Resident 4's medical record was reviewed on 5/6/24. Review of resident 4's physician orders revealed the following: a. Chlorthalidone Oral Tablet give 12.5 mg (milligrams) by mouth one time a day for HTN (hypertension). Hold for systolic less than 110. b. Amlodipine Besylate Oral tablet 5 MG Give 1 mg by mouth one time a day for hypertension. Hold for systolic less than 110. Review of resident 4's March, April and May 2024 Medication Administration Records (MARs) revealed the following: c. Chlorthalidone 12.5 mg was administered when it should have been held for a blood pressure of 102/65 on 3/17/24. d. Amlodipine 5 mg was administered when it should have been held for a blood pressure of 105/62 on 4/7/24. e. Chlorthalidone 12.5 mg was administered when it should have been held for a blood pressure of 96/68 on 5/5/24. On 5/8/24 at 8:06 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated some residents have blood pressure parameters that the physician has ordered. RN 1 stated the nurses are supposed to check the residents blood pressure to make sure it is at an ok level before administering their blood pressure medications so their blood pressure does not drop too low. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/9/24 at 9:26 AM, an interview was conducted with the Director of Nursing (DON). The DON stated the facility did have blood pressure parameters that were ordered by the physician and the nurses were expected to follow those parameters when administering medications. If the blood pressure was under the parameter the nurses were expected to hold the medication, make the physician aware and await further orders. The DON stated there are parameters in place to keep the residents safe.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44640 Based on observation and interview, the facility did not label all drugs and biologicals used in the facility in accordance with currently accepted professional principles and included appropriate accessory instructions and the expiration date when applicable. Specifically, narcotics were repackaged into the narcotic medication cards. Findings include: On 5/8/24 at 8:35 AM, an observation was made of the facility medication cart for the Quail hallway serving rooms 31 - 42. The following medication was located inside: a. A medication card which held Tramadol 50 mg (milligrams) had the back of pockets numbered 10 and 20 taped, there was a white tablet observed to be in each of the pockets. On 5/8/24 at 8:45 AM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated that 2 nurses are supposed to waste narcotics, and they are usually placed in the sharps container then both nurses sign the narcotic book. RN 2 stated the narcotics are not supposed to be taped back into the narcotic card. On 5/9/24 at 9:17 AM, an interview was conducted with the Director of Nursing (DON). The DON stated the nurses are expected to waste narcotics with another nurse and sign it as completed in the narcotic book. The DON stated the nurses are not supposed to re-tape any medication back into the medication cards as this could increase the chance of infection and the wrong medication being placed in the medication card.

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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. 44640 Based on observation and interview it was determined, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, for 1 out of 38 sampled residents, a staff member was observed to touch a resident medications with bare hands with each medication administration. Also medications were dropped on and in the medication cart and then administered to the residents Findings include: On 5/8/24 at 8:20 AM, during morning medication pass the following was observed: a. At 8:32 AM Registered Nurse (RN) 2 was observed to not use hand hygiene prior to starting medication pass. RN 2 was observed to use her right index finger to retrieve a medication placed in the medication cup in error. After RN 2 had stuck her finger into the cup she was observed to then remove her finger and obtain a spoon to retrieve the medication from the cup. RN 2's finger was observed to have already touched the medications and sides of the medication cup. b. At 8:36 AM RN 2 was observed to obtain a tablet from a bottle with her bare fingers and place the tablet on the pill cutter. RN 2 was observed to cut the medication, pick up half of the tablet with bare fingers and place the half tablet into the medication cup. The medication cup was then administered to a resident. On 5/8/24 at 8:40 AM, an interview was conducted with RN 2. RN 2 stated hand hygiene was done when passing medications and medications were not supposed to be touched with bare hands to keep them clean for the residents. On 5/9/24 at 9:17 AM, an interview was conducted with the Director of Nursing (DON). The DON stated the nurses are expected to use hand hygiene when administering medications. The DON stated the nurses are not supposed to touch the medications, and if they do they are expected to start the medication pass over for that resident. The DON stated medication pass education needed to be completed.