STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175274	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meridian Rehabilitation and Health Care Center	1555 N Meridian Street Wichita, KS 67203

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 96 residents, that included 20 residents included in the sample. Based on interview and record review, the facility failed to include Resident (R)61 in the development and planning of the resident's care plan quarterly, which placed R81 at risk of impaired care and autonomy. Findings included: - Resident (R)61's Electronic Medical Record (EMR) documented diagnosis that included acute kidney failure, Human immunodeficiency virus (HIV is a virus that attacks cells that help the body fight infection, making a person more vulnerable to other infections and diseases) and muscle weakness. The admission Minimum Data Set(MDS) dated [DATE], documented R61 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. R61 had verbal behavioral symptoms four to six days, but less than daily during the look-back period. It was somewhat important to have family, or a close friend involved in discussions about his care. He required staff assistance with activities of daily living (ADL). He had occasional incontinence of bladder. He had obvious or likely cavity or broken natural teeth. R61 had moisture associated skin damage (MASD) and used a pressure reducing device for his chair and bed. Section Q of the MDS documented participation in assessment and goal setting checked as resident participation. The Care Area Assessment (CAA) triggered for Cognitive loss/dementia, ADL Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Psychosocial well-being, Behavioral symptoms, Nutritional Status, Dehydration/Fluid Maintenance, Dental care, and Pressure ulcer(localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). The quarterly MDS, dated [DATE], documented R61 had a BIMS of 15, indicating intact cognition. The quarterly MDS, dated [DATE], documented R61 had a BIMS of 15, indicating intact cognition. The care plan documented the resident had a potential psychosocial well-being problem and guided staff to provide opportunities for the resident and family to participate in care, dated 12/13/24. Review of the EMR revealed on 10/18/23 Interdisciplinary care conference notes, revealed the resident and the MDS staff attended the care plan conference. The EMR lacked documentation of any further attendance or invitation to discuss his care plans. (continued on next page)

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/30/24, R61 reported he had never been given the opportunity to participate in his care plan, and he felt it was important to be in on the care plan. On 07/31/24 at 03:59 PM, Social services staff X reported staff should give residents the opportunity to go to their care plan. Staff should document in the social service note if the resident attended or did not attend. On 07/31/24 at 04:16 PM, Administrative Nurse E reported staff should invite R61 to his care plan and verified the facility lacked documentation in his EMR whether he was invited or if he chose to come/refuse his care plan meeting. On 08/01/24 at 11:36 AM, Administrative Staff A reported it is the expectation of the facility staff to give a notice of the care plan to the resident on the day of the care plan meeting. If a resident would like to participate in the care plan meeting, staff would review and verify information including code status, diet, transfers, and such. The facility had care plan meetings generally every Tuesday. The facility's undated policy for Care Plan Meeting, documented Federal law provides that, to the extent possible, the resident, the resident's family, or the resident's legal representative should participate in the care plan meeting. It is important to provide plenty of notice and multiple options for their participation (i.e telephone conference, virtual meeting, or in-person). An Interdisciplinary Care Conference Notes Assessment should be completed during the care plan meeting. The facility failed to include Resident (R)61 in the development and planning of the resident's care plan quarterly, which placed R81 at risk of impaired care and autonomy.

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 96 residents. The sample included 20 residents with four residents selected for review related to resident rights to retain and use of their personal possessions. Based on observation, interview , and record review, the facility failed to ensure the resident right to retain and use her personal possessions for Resident (R)63 related to her motorized wheelchair and R 54's missing coat. Findings included: - Review of Resident (R)63's Physician Orders, dated 07/09/24 documentation included diagnoses of diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), cellulitis (skin infection) of left lower limb, chronic obstructive pulmonary disease, (COPD-progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and generalized muscle weakness. The admission Minimum Data Set (MDS) dated [DATE], documentation included a Brief interview for Mental Status, (BIMS) score of 14, indicating cognitively intact. She did not exhibit any behaviors but reported little interest or pleasure in doing things, feeling down, depressed, hopeless, and feeling tired or having little energy. Additionally, the resident stated taking care of her personal belongings, going outside when the weather was good, and participation in her favorite activities were very important. She did not smoke. The resident used a manual wheelchair as a mobility device and noted as independent with wheeling her wheelchair for 150 feet. She received application of ointments (treatment medications) and dressings to manage skin problems to her feet and other than her feet. She received schedule and prn (as needed) pain medication. The resident reported moderated pain and experienced one non-injury fall. The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) and Psychosocial Wellbeing CAA dated 06/05/24, documentation included respectively the resident required staff assistance with daily care needs, transfers, and mobility for proper completion and safety as needed to avoid complications and minimize risks related to psychosocial wellbeing. The Care Plan, dated 06/05/24, directed staff the resident had mood problem related to depression and anxiety. Staff were to monitor/record/report to the physician as needed episode of feelings sadness, loss of pleasure, and interest in activities. Review of R 63's electronic medical record (EMR), Social Service Progress Note (PN) dated 0/31/24 at 07:24 PM, documentation included Social Service staff X talked to the administrator and asked if R 63 had a motorized scooter in the building. Administrative Staff A referred Social Service Staff X to maintenance to see if the electric chair was located in the building. The maintenance reported to Social Service staff X, that three weeks prior, R 63's previous care facility delivered her electric wheelchair to the current facility and had been stored at the facility. The EMR lacked documentation the resident had been notified of the delivery and/or the location of her wheelchair. On 07/30/24 at 11:50 AM, Resident (R)63 sat in a manual wheelchair. She had kerlex wraps (type of (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bandage) on her legs . She was alert, oriented, and identified herself as a resident that smoked. She stated she had to use her manual wheelchair to navigate the hallway to the smoking area at the courtyard off of the 100 hall. The resident reported she had a diagnoses which included diabetes and wounds on her legs, and she could not use her feet to self- propel her wheelchair. She had to use her hands to propel the wheelchair to the smoking area which was a long way from her room (approximately 300 feet away from the resident's room). R 63 reported the facility had designated smoking times and by the time she self-propelled her wheelchair to the designated area, she was exhausted and could not use her full-time smoking. R 63 started crying and stated she had an electric wheelchair she had bought with her own money that had been delivered to the facility and she did not know where it was. She reported the electric wheelchair would help her to be able to attend her favorite activities and be more independent. No one at the facility had let her know the electric wheelchair was at the facility. On inquiry, R 63 reported no one had set up an assessment to determine if she could safely operate the electric wheelchair. However, she knew the facility allowed electric wheelchairs because other residents in the facility used them. She stated she knew the electric wheelchair had been delivered to the facility because she had checked on it. On 07/31/24 at 11:59 AM, Social Service Staff X stated she was not aware of the resident having an electric wheelchair at the facility and/or needing an electric wheelchair assessment to determine her ability to operate the wheelchair safely. She agreed the residents had a right to retain and use their personal possessions. Social Service Staff X reported she would follow-up with the facility Administrator and or maintenance staff to investigate the resident's electric wheelchair location. On 07/31/24 at 02:37 PM, Certified Nurse Aide M stated she was not aware the resident had an electric wheelchair at the facility. The resident could self-transfer to her wheelchair, and she would not get as tired with an electric wheelchair. On 08/05/24 at 03:00 PM, Administrative Staff A confirmed the above findings. Additionally, he reported the resident did not have access to or use of her electric wheelchair while it was in storage. The facility lacked a policy for Resident Rights, related to the resident's right to retain and use personal property. The facility failed to ensure the resident right to retain and use her personal possessions related to her motorized wheelchair. -Resident (R) 54's Electronic Health Record (EHR) revealed diagnoses that included dementia (progressive mental disorder characterized by failing memory, confusion) and muscle weakness. The 05/28/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. R54 had a total mood severity score of 00, indicating no depression and there were no behaviors documented on the assessment. The 07/23/24 Quarterly MDS documented a BIMS score of 14. No behaviors. R54 was independent with ADLs, except set-up for shower. The Care Plan documented R54 wanted take care of his personal belongings dated, 07/06/20. Review of the Progress Notes from 01/01/24 to 07/30/24 lacked any notes regarding missing personal property. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/30/24 at 09:27 AM, R54 stated his topcoat required new buttons and dry cleaned. He stated that Social Service Staff X assisted with that task. R54 stated his topcoat had been missing for a couple of months and had requested to have it returned. He stated as he threw both of his arms up in the air looking frustrated that he had spoken to Administrative Staff A and Social Service Staff X a few times with no return of his coat. On 07/31/24 at 12:53 PM, Administrative Staff A stated he was not aware of R54 missing a topcoat. Administrative Staff A stated that R54 was very particular of all his personal items and that R54 had assistance with his dry cleaning of an un-named person. On 07/31/24 12:55 PM, Social Service Staff X stated that R54 informed her yesterday that his topcoat had been missing since it was taken for dry cleaning. On 08/01/24 at 02:00 PM, Administrative Staff A revealed that R54's topcoat had been located by Social Service X and brought back the topcoat from the dry cleaners. He stated the buttons were not replaced, but the topcoat was cleaned. On 08/01/24 at 02:30 PM, Social Service Staff X confirmed she returned R54's topcoat. However, she could not recall when she received R54's coat to have it dry cleaned. The facility lacked a policy on personal property. The facility failed to ensure (R)54 received his personal property back in a timely manner. This deficient practice placed the resident at risk for decreased psychosocial well-being.

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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** The facility reported a census of 96 residents. Based on observation, interview, and record review, the facility failed to prevent the neglect of cognitively impaired Resident (R)53, who had mental health disorder diagnoses, anger related to living in the facility, and a history of exit seeking, and the facility staff did not respond to his suicidal ideation statements after his elopement (when a cognitively impaired resident leaves the facility without the knowledge or supervision of staff). On [DATE], R53 eloped from the facility. When staff returned R53 to the facility, they placed a Wander Guard (a bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) on R53, and he reported he would never eat again. On [DATE] at 04:00 PM, R53 made statements such as give me a gun so I can shoot myself. At 10:00 PM, the resident reported he was being held against his wishes. On [DATE] at 11:30 AM, R53 reported he would not eat until someone came back to talk about him being dismissed. Staff told R53 it may be a while before someone could get to him as there are others in need of services. On [DATE] at 10:02 AM, staff assessed R53 for exit seeking behaviors and continued 15-minute checks for 24 hours until reassessed. On [DATE], new orders were received to increase Seroquel 50 mg to three times a day. On [DATE] at 03:30 PM, staff found R53 had hung himself in his room with the TV cable on the closet door frame. This deficient practice placed R53 in immediate jeopardy. Findings included: - Review of the Electronic Health Record (EHR), documented R53 had diagnoses which included dementia (a progressive mental disorder characterized by failing memory and confusion) and bipolar (major mental illness that caused people to have episodes of severe high and low moods) and conduct disorder (a group of behavioral and emotional problems characterized by a disregard for others). The [DATE] Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. R53's total severity score of 00, indicating no depression. The MDS documented the resident did not have behaviors during the look back period. R53 was independent with all his activities of daily living (ADL). The [DATE] Behavioral Symptoms Care Area Assessment (CAA) documented R53 had episodes of agitation and anxiety and staff would proceed to care plan with continued monitoring and assistance as needed to avoid complications and minimize risks related to behaviors, with referral to physician and/or psychiatric services as needed. The [DATE] Quarterly MDS documented R53 had a BIMS score of nine, which indicated moderately impaired cognition. The MDS indicated no depression for the resident. R53 had become very anxious and agitated about why he was at the facility and when/why he could not go home for four to six days in the seven-day look-back period. R53 was independent with all his ADL. The [DATE] Care Plan documented an intervention, dated [DATE], indicating R53 was not allowed outside of the community, independently. Staff were instructed to provide redirection, diversion, and reorientation if R53 became restless, agitated, or exit seeking. The staff were to consult the physician if R53 was not easily redirected or had continued behaviors. The resident was an elopement risk/wanderer. R53 had an actual elopement from the facility. R53 had depression and anxiety and was on a daily psychotropic medication for management, dated [DATE]. The staff would monitor, record, and (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	report to physician as needed for harm to self, suicidal ideation's, or refusal to eat or take medications. The [DATE], Elopement Assessment documented R53 was not at risk for elopement, however the assessment documented R53 was cognitively impaired, an exit seeker, diagnosed with dementia, and required a secured unit. Review of the Progress Note revealed on [DATE] at 06:03 PM, R53 was upset about having to wait to get help to get out of the facility. R53 stated he was going to go, one way or another. The [DATE] Nurse Practitioner Note documented R53 required long term care placement in a memory care unit due to high elopement risk. Furthermore, R53 was upset to still be living in a nursing facility and had daily aggression. Review of the Progress Note revealed on [DATE] at 01:42 PM, R53 stated if he did not get dismissed, he would sneak out the back door at night. The Progress Note on [DATE] revealed the following: At approximately 07:15 AM, staff could not locate R53. At approximately 08:30 AM, the staff located R53 approximately two miles away from the facility. At 09:00 AM, Emergency Medical Services (EMS) transported R53 to the hospital for psychological evaluation and medical clearance after his elopement. At 03:00 PM, R53 returned to facility from the hospital. The staff placed a Wander Guard bracelet (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) to R53's right wrist and placed R53 on one-hour checks for the following 72 hours. The Progress Note on [DATE] revealed: At 01:28 PM, staff found R53 at his window and when asked what he was doing. R53 questioned when am I getting out of here? The Wander Guard bracelet was not on R53's wrist, it was located behind the TV in R53's room. The staff notified Physician Extender TT, who instructed staff to give R53 space to calm down and reapproach the resident in a few hours. At 02:30 PM, R53 continued to be adamant about leaving the facility and the staff contacted Administrative Nurse D. At 03:30 PM, Administrative Nurse D instructed staff to send R53 to the hospital for evaluation, per provider order. At 04:00 PM, staff informed R53 that EMS was on route to transport him to a hospital. R53 continued to make comments such as give me a gun so I can shoot myself. Staff were instructed to keep watch on the agitated resident. At 04:30 PM, R53 left the facility with EMS. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At 10:00 PM, R53 returned to the facility, aggravated that he was back, and with one-on-one in place at that time. The Progress Note on [DATE] at 06:39 PM, revealed the staff continued with one-on-one monitoring for R53 and the resident was verbally aggressive toward staff. The [DATE] Physician Orders included an order for the Electronic WanderGuard bracelet to be applied to R53, staff to validate the functioning every night shift. The Progress Note on [DATE] revealed: At 08:05 AM, Physician Extender TT updated on R53's continued aggressive behavior and refusal to take medications. Physician Extender TT recommended an inpatient psychiatric stay. At 08:25 AM, the facility nurse spoke to the hospital nurse, who suggested to send R53 to the hospital for evaluation. The Progress Note on [DATE] at 01:36 PM revealed the facility nurse spoke with the nurse at 11:00 AM and was informed R53 would be diverted to another hospital for admission to a Behavioral Health Unit (BHU). At 11:30 AM, EMS transported R53, who left willingly, however he stated, I will murder you if I have a reason too. The Progress Note on [DATE] at 05:20 PM, revealed R53 returned to facility, accompanied by EMS, with no new orders. The [DATE] Physician Order required staff to check for the placement of the WanderGuard bracelet on every shift. The Progress Note on [DATE] at 11:30 AM, revealed R53 refused his lunch meal and stated he would not eat again until someone came back to talk to him about his dismissal. The staff advised R53 that it may be a while before someone could talk to him as there were others in need of services. R53 continued to stand at an exit door to watch staff enter the code to the door. The Progress Note on [DATE] at 02:37 PM, revealed staff noted a referral sent to a BHU at 11:15 AM due to increased behaviors. The BHU contacted the facility at 12:30 PM and informed them there were no beds available. The staff contacted a second behavioral unit and was informed there were no beds available. Staff sent a referral out to a third BHU at 02:41 PM, however, that unit staff stated the referral was not received and the referral was re-faxed. The Progress Note on [DATE] at 03:06 AM, revealed R53 continued one-on-one supervision. R53 remained in his room. The Progress Note on [DATE] at 10:02 AM, revealed the Administrative Nurse F assessed R53 for exit seeking behaviors. R53 was at baseline and staff would complete fifteen-minute checks for 24 hours. The Progress Note on [DATE] at 10:06 AM, revealed Administrative Nurse F assessed the resident and noted R53 continued at baseline and staff discontinued the fifteen-minute checks. Physician Extender TT's signed [DATE] Psychiatric Progress Note regarding the visit on [DATE] at (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	02:30 PM to 02:45 PM, documented R53 appeared disheveled, displayed irritable behavior, and had poor insight and impulse control. R53 remained focused on being released and became demanding and easily agitated. R53's conversation was tangential (different from or not directly connected with the one you are talking about) in nature, which further complicated the conversation and understanding R53's concerns. The staff reported R53's recent elopement and ongoing agitation and aggression. New order to increase on [DATE] at 12:45 PM, for R53's Quetiapine fumarate, 50 mg tablet to three times a day, for continued issues with mood and behavior. The Progress Note on [DATE] at 12:59 PM, noted R53 continued to ask for dismissal orders. The EHR lacked Progress Notes between the [DATE] at 12:59 PM and the [DATE] at 03:30 PM Progress Note. The Progress Note on [DATE] documented: At 03:30 PM, R53 was in his bed at 06:00 AM, with his eyes closed and breathing. At 08:00 AM, staff administered R53's medications and R53 asked staff when he was leaving. At approximately 11:30 AM, staff delivered lunch to R53 in his room. He asked how long he had been at the facility. At approximately 01:00 PM, R53 brought his lunch dish to the nurse's station. At approximately 03:30 PM, the staff found R53 hanging from his closet. The staff contacted the facility's management team. At 03:38 PM, Administrative Nurse D and Administrative Nurse F entered R53's room and found R53 hanging from the television cable on the closet door frame. The staff assisted R53 to the floor and began cardiopulmonary resuscitation (CPR- emergency lifesaving procedure performed when the heart stops beating). The staff called 911 and continued CPR. At 04:00 PM, EMS arrived and took over CPR. Social Service Designee contacted the guardian. At 04:05 PM, time of death was announced as EMS/Medical Coroner stopped all compressions per the guardian's request. Review of the Facility Investigation dated [DATE] revealed through record review and interview of staff, family, and physician services, determined that R53 had a previous history of possible suicide ideation's. It was determined at the time of the event, R53 was not known to be a danger to himself or others and had remained stable per his baseline. Observation on [DATE] at 11:30 AM, revealed the memory care unit courtyard exit required a code to exit and enter. There was a six-foot wooden fence that surrounded the courtyard and attached to the building. There was a small alcove area that was near the exit door, not completely visible for staff to observe when they looked out the windows to the courtyard. During an interview on [DATE] at 11:38 AM, CNA Q reported R53 eloped in 2022, and she did not know when R53 had his Wander Guard removed after the elopement in 2022. CNA Q stated she had been (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	educated previously to never let a resident outside by themselves in the courtyard. R53 had exit seeking behaviors as he would state he wanted to leave. CNA Q said the green patio chairs in the courtyard were removed after R53 eloped on [DATE]. She also confirmed she received education after R53 eloped in [DATE] and she received education about abuse, trauma, and suicide in July after the incident. During an interview on [DATE] at 02:26 PM, CNA MM stated R53 always asked him about being able to leave the facility. CNA MM stated that he received education about elopement, abuse, and trauma after R53 eloped on [DATE]. He also stated that R53 never made verbal comments of hurting himself and he had received training on suicide. During an interview on [DATE] at 02:26 PM, CNA NN stated R53 always asked about leaving the facility and wanted to live somewhere else. CNA NN stated he received education after R53 eloped, that included elopement, abuse, and trauma. He also stated that R53 never made verbal comments of hurting himself and he had received training on suicide. On [DATE] at 03:40 PM, Licensed Nurse (LN) I stated she could not locate R53 on [DATE] at approximately 07:15 AM and said CNA P last observed R53 in the courtyard. LN I stated she checked the sign-out book and confirmed R53 had not signed out of the facility. Staff could not locate R53 on the unit and contacted all staff on pager system and announced a Dr. Walker at approximately 07:30 AM. Administrative staff B located the resident at approximately 08:30 AM and brought him back to the facility. LN I confirmed R53 was very agitated about residing at the facility and his behaviors were almost daily. LN I was not sure if R53 had a previous elopement from the facility. LN I stated R53 was antsy and agitated and wanted to get out. She stated that R53 was placed on one-on-one observations 24 hours a day for about two weeks. LN I stated several staff members took turns with R53's one-on-one observation. LN I reviewed Physician Extender TT psychiatric progress note that was received on [DATE], however Physician Extender TT assessed R53 on [DATE]. LN I stated that Physician Extender would write new orders in the facility if needed and that waiting six days for new orders after a visit is not usual. LN I stated R53 was very agitated about being in the facility and never voiced any suicidal ideation's to her. LN I verified R53 had no progress notes charted in the EHR between the [DATE] at 12:59 PM progress note and the [DATE] at 03:30 PM progress note, when R53 was found hung in his room. LN I stated he was still wanting to leave but not as aggressive during that time period or a note would have been written, and stated the nurses' chart by exception. LN I also stated they do not chart notes on psych (antipsychotic- class of medications used to treat major mental conditions which cause a break from reality) medications when changed, unless there was a concern. She stated the nurses would have to chart a lot on the residents, as psych medication changes occur often. LN I stated she had education for elopement, abuse, trauma, and suicidal ideation's signs and symptoms and to report concerns immediately to management. On [DATE] at 12:02 PM, LN G stated she was not at work the day R53 eloped from facility on [DATE]. She stated that she would not let a resident outside by themselves. LN G revealed that R53 was an exit seeker since the first day he admitted in December of 2022, and was not given a Wander Guard bracelet until after he eloped in December of 2022 shortly after he admitted to the facility. LN G could not recall when staff removed R53's wander guard bracelet. LN G stated that is not normal to receive new orders several days after a resident was seen by a provider. LN G stated that no progress notes were required after a medication change unless there was a concern. LN G stated she last saw R53 on [DATE] and he was his normal self. She confirmed that she received education after both incidents occurred, that included abuse, elopement, trauma, and suicidal ideation's and the facility had an elopement drill. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meridian Rehabilitation and Health Care Center	1555 N Meridian Street Wichita, KS 67203

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 03:00 PM, Administrative Nurse D stated that Physician Extender TT generally did not write orders in the facility when she assessed residents. Administrative Nurse D said Physician Extender TT would email to her all the signed progress notes with orders written on them if she wrote new orders. She stated it would take several days to receive the progress notes and orders back from Physician Extender TT and stated that was not acceptable. Administrative Nurse D confirmed that nurses generally charted when there was a concern. On [DATE] at 11:49 AM, Administrative Nurse F stated residents from the memory care units were not allowed to go outside in the courtyard or off the units independently. She stated R53 had always been an elopement risk and staff received education on abuse, elopement, suicidal ideation's, and trauma. She stated that the facility tried to assist R53 to get admitted to a behavioral unit a few times and he would just be sent back from the hospital. On [DATE] at 03:50 PM, phone interview with Physician Extender TT, revealed the progress notes and orders received for R53 on [DATE] from her visit on [DATE] was later than normal. She stated it typically took 48-72 hours to write, sign, and email the progress notes and orders to the Administrative Nurse D. Physician Extender TT verified she would not write orders at the facility during a visit, due to the number of residents she saw there. She stated she was not updated on R53's comment from [DATE] that he would shoot himself if he had a gun. Physician Extender TT stated she received her information from the Administrative Nurse F and the Administrative Nurse D and said the staff on the unit were not the best resource for information needed. She confirmed R53 should have received the order for his medication increase sooner than he did. The facility Suicide Threats policy dated 02/2021 documented if a resident made a suicidal threat, stay with the resident, and immediately notify the nurse. The nurse would assess the resident and notify the Director of Nursing or designee and medical provider to establish a plan of care. The resident's environment would be evaluated, and potentially dangerous items removed. The interdisciplinary team would review documentations and behaviors and revise the plan of care. The facility failed to prevent the neglect of cognitively impaired, R53, with known mental illness and anger related to placement in the facility, when staff failed to respond to his suicidal ideation comments after he eloped from the facility on [DATE]. This deficient practice placed R53 in immediate jeopardy, and R53 hung himself with a cable cord from his closet door. On [DATE] at 09:10 AM, Administrative Staff A and Consultant Staff SS were provided the Immediate Jeopardy (IJ) template and notified the facility failed to prevent the neglect of cognitively impaired, R53, with known mental illness and anger related to placement in the facility, when staff failed to respond to his suicidal ideation comments after he eloped from the facility on [DATE]. This deficient practice placed R53 in immediate jeopardy, and R53 hung himself with a cable cord from his closet door on [DATE]. The facility identified and implemented the following corrective actions, completed on [DATE] after R53's suicide: 1. An Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting held by interdisciplinary (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	team on [DATE]. 2. The Administrator notified the Medical Director on [DATE] at 09:00 AM. 3. The [NAME] President of Clinical Operations re-educated the Administrator and Director of Nursing on community process for recognizing signs and symptoms of suicidal on [DATE]. 4. The Corporate Director of Clinical Reimbursement educated the Administrator, Social Service staff, and Director of Nursing regarding the community process of the social service comprehensive assessment and trauma informed care assessment. Education included intended scheduled, psychosocial care planning of 5. Current associates will be re-educated by the community by the Administrator or designee on or before [DATE] or prior to working next scheduled shift on community. Trauma Informed Care process with specific focus on identification of suicidal symptoms and suicidal ideation, required notifications and immediate actions. 6. Social Service comprehensive assessments will be completed upon admission, annually and with significant change. Assessment will be documented in resident medical record. 7. Residents identified with need for trauma preventative services will have a trauma informed assessment completed upon admission, annually and with identified significant change in condition. Assessments will be documented in resident medical record. Care plan will be updated as indicated. 8. Routine angle rounds will be completed by assigned interdisciplinary team members routinely and will include staff members interviews to validate understanding of resident suicide awareness and notification requirements. Results of the angel rounds will be reported during routine morning stand up meetings. If discrepancies are identified immediate one on one educations will be completed with associate involved. 9. During weekly risk review meetings, the interdisciplinary team will review the clinical record of newly admitted residents or residents identified change in condition to validate completion of required social service assessments and or trauma informed care evaluations when indicated. The review will be documented in the resident medical record. 10. The Administrator or designee will routinely review sample selected residents for the next 60 days to validate compliance of the following: completion of the social service comprehensive assessment as appropriate, completion of trauma informed care assessment as appropriate, psychosocial care plan present when indicated that include resident specific interventions based upon assessment (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	findings; any noted suicidal ideation as indicated. 11. Monthly review of completed weekly risk review and angle rounds results and trends will be completed by the Administrator or designee and reported to the QAPI committee for the next three months and then re-evaluate to determine if further monitoring is indicated. Due to the corrective actions the facility completed prior to the onsite visit, the deficient practice was deemed past non-compliance and existed at a J scope and severity.

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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. The facility reported a census of 96 residents and the facility identified five residents at risk for elopement. Based on observation, interview, and record review the facility failed to provide adequate supervision to cognitively impaired, independently mobile Resident (R)53, identified as a high risk for elopement. On 06/29/24 at approximately 07:15 AM, staff were unable to locate R53 in the facility. On 06/29/24 at approximately 08:30 AM, staff located R53 approximately two miles away from the facility. R53 walked down busy residential areas with a 35 mile per hour speed limit and would have crossed 20 cross walks and crossed over two river bridges. This deficient practice placed R53 in immediate jeopardy. Furthermore, the facility failed to keep R54 safe, related to fall hazards in R54's room. Findings included: - Review of the Electronic Health Record (EHR) documented R53 had diagnoses, which included dementia (a progressive mental disorder characterized by failing memory and confusion), bipolar (major mental illness that caused people to have episodes of severe high and low moods) and conduct disorder (a group of behavioral and emotional problems characterized by a disregard for others). R53 admitted to facility on 12/07/2022. The 11/20/23 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. R53 had a total mood severity score of 00, indicating no depression and there were no behaviors documented on the assessment. R53 was independent with all his activities of daily living (ADLs). The 11/20/23 Behavioral Symptoms Care Area Assessment (CAA) documented R53 had episodes of agitation and anxiety. Staff would care plan continued monitoring of the resident and provide assistance as needed to avoid complications and minimize risks related to behaviors, with referral to physician and/or psychiatric services as needed. The 05/16/24 Quarterly MDS documented a BIMS score of nine, which indicated moderately impaired cognition. No depression noted. R53 was very anxious and agitated about why he was at the facility and when/why he could not go home for four to six days of the seven-day look-back period. R53 was independent with all his ADLs. The 07/22/24 Care Plan documented an intervention, dated 12/09/22 instructing staff R53 was not allowed outside of the community independently. Staff were instructed to provide redirection, diversion, and reorientation if R53 became restless, agitated, or began exit seeking. Staff would consult the physician if R53 was not easily redirected or had continued behaviors. The resident was an elopement risk/wanderer and on 12/09/22, R53 had an actual elopement from the facility. The Elopement Assessments revealed the following for R53: On 12/27/22, 12/09/22, 12/15/22, 03/10/23, 07/10/23, 08/21/23, 11/14/23 and 02/15/24, R53 was identified at risk for elopement. On 05/13/24 Elopement Assessment, documented R53 was not at risk for elopement, however the assessment documented R53 was cognitively impaired, an exit seeker, diagnosed with dementia, and required a (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	secured unit. Review of the Progress Notes from 01/01/24 to 06/29/24 revealed the following: On 04/09/24 at 06:03 PM, R53 was upset about having to wait to get help to get out of the facility. R53 stated he was going to go one way or another. On 06/22/24 at 01:42 PM, R53 stated if he did not get dismissed, he would sneak out the back door at night. On 06/29/24 at approximately 07:15 am, staff were unable to locate R53. The facility notified Law Enforcement at approximately 08:00 AM. Staff were able to locate R53 at around 08:30 AM approximately two miles away from the facility. Review of the Nurse Practitioner Note dated 06/11/24, documented R53 required long term care placement in a memory care unit due to high elopement risk. Furthermore, R53 was upset to be still living in a nursing facility and had daily aggression. Review of the Facility Investigation, revealed on 06/29/24 at approximately 06:00 AM, Licensed Nurse (LN) J and Certified Nurse Aide (CNA) N provided R53 access to the courtyard to consume a cup of coffee independently. CNA N passed in report to the oncoming CNA O where R53 was. At approximately 06:45 AM, CNA P verified R53 was in the courtyard patio on the bench, with his hands folded, dressed in shirt, pants, and tennis shoes. At approximately 07:15 AM, LN I could not locate R53 and instructed CNA O and CNA P to search the entire Memory Care Unit as R53 was an elopement risk. LN I checked the sign-out book and verified R53 was not signed out. At approximately 07:30 AM, LN I, CNA O, and CNA P confirmed R53 was not in the unit or the courtyard. CNA O located a patio chair placed in the corner of the six-foot-tall fence. LN I initiated the elopement procedure and called a Dr. [NAME] code for (missing resident) over the pager system to alert all staff. All staff assisted with the search of R53 inside and outside of the facility. Staff members drove around the area of the facility, without locating R53. At approximately 07:50 AM, the Police Department was notified of R53 missing from the facility. At approximately 08:25 AM, Administrative Staff B located R53 located approximately two miles from the facility. Administrative Staff B brought R53 back to the facility at approximately 08:45 AM. The physician ordered R53 to a hospital emergency room for a psychological evaluation. Emergency medical staff transported R53 to the hospital at 09:00 AM. Observation of the area R53 would have presumably walked down was a busy residential area with a 35 miles per hour speed limit and R53 would have crossed 20 cross walks and crossed over two river bridges. Review of the weather data for the facility area from Weather Underground (www.wunderground.com) on 06/29/24 at approximately 06:45 AM, was daylight and the temperature was 77 degrees Fahrenheit. On 07/30/24 at 03:40 PM, LN I stated she could not locate R53 on 06/29/24 at approximately 07:15 AM and stated that CNA P last observed R53 in the courtyard. She instructed CNA P and CNA O to complete a thorough check of the unit to locate R53. LN I stated she checked the sign-out book and confirmed R53 had not signed out of the facility. Staff could not locate R53 on the unit and contacted all staff on pager system and announced a Dr. Walker at approximately 07:30 AM. LN I stated she contacted Administrative Nurse F and contacted the Police Department at approximately 08:00 AM as staff had not yet located R53. Some of the staff drove their own vehicles to locate R53. The Police Department (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	arrived at the facility around 08:08 AM and were given a description and picture of R53. Administrative staff B located the resident at approximately 08:30 AM and he was brought back to the facility. LN I confirmed R53 was very agitated about having to reside at the facility and his behaviors were almost daily. LN I was not sure if R53 had a previous elopement from the facility. On 07/31/24 at 11:38 AM, CNA Q reported R53 had an elopement in 2022, she was unsure when R53 had his Wander Guard (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) removed after the elopement in 2022. CNA Q stated she had been educated previously to never let a resident outside by themselves in the courtyard. R53 had exit seeking behaviors as he would state he wanted to leave. The green patio chairs in the courtyard were removed after R53 eloped on 06/29/24. She also confirmed that she received education after R53 eloped in June 2024. On 07/31/24 at 02:26 PM, CNA MM stated R53 always asked him about being able to leave the facility. CNA MM stated he received education about elopement, abuse, and trauma after R53 eloped on 06/29/24. On 07/31/24 at 02:26 PM, CNA NN stated R53 always asked about leaving the facility and wanted to live somewhere else. Stated that he received education after R53 eloped on elopement, abuse, and trauma. On 07/31/24 at 11:49 AM, Administrative Nurse F stated no residents from the memory care units were allowed to go outside in the courtyard or off of the units independently. She stated R53 had always been an elopement risk and staff received education on abuse, elopement, and trauma. Observation on 07/31/24 at 11:30 AM, the memory care unit courtyard exit required a code to exit and enter. There was a six-foot wooden fence that surrounded the courtyard and attached to the building. In the courtyard there was a small alcove area that was near the exit door, not completely visible for staff to observe when they looked out the windows to the courtyard. The facility Elopements policy dated 05/2023 documented it is the policy of the facility that all residents were afforded adequate supervision to provide a safe environment possible. Residents who are at risk for elopement are provide with at least one of the following safety precautions. 1. Door alarms on facility exit 2. A personal safety device that will alert facility when resident has left the building without supervision. (Wander guard bracelet). 3. Staff supervision. The facility failed to provide adequate supervision to cognitively impaired, independently mobile R53, identified as a high risk for elopement. On 06/29/24 at approximately 07:15 AM, staff were unable to locate R53 in the facility. R53 was found approximately 45 minutes later, at 08:30 AM, approximately two miles away from the facility. This deficient practice placed R53 in immediate jeopardy. On 07/31/24 at 09:10 AM, Administrative Staff A and Consultant Staff SS were provided the Immediate (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Jeopardy (IJ) template for failure to provide R 53, a cognitively impaired resident who had a history of making comments about leaving, was identified as an elopement risk, and had anger issues regarding placement in the facility a safe environment from leaving the facility without staff knowledge. The immediate jeopardy was determined to first exist on 06/29/24 at 06:00 AM, when staff left R53 unsupervised, outside on a memory care unit and he climbed a fence, left the facility, and was located approximately two miles away. The facility identified and implemented the following corrective actions, completed on 07/02/24: 1. The Community Interdisciplinary Team completed a review of the community on 07/02/24 with four additional residents identified as being at risk for elopement and placed in wander guard alarms. 2. An Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting held by interdisciplinary team on 06/29/24. 3. The Administrator notified the Medical Director on 06/29/24. 4. Current clinical associates were re-educated by the Director of Nursing or designee before 07/02/24, or prior to working next scheduled shift on the Community Elopement policy and Community Elopement Evaluation process. Education included identification of at -risk residents, and courtyard oversight requirements. 5. Residents with a new risk for elopement or change in elopement risk will be reviewed by clinical interdisciplinary team during routine clinical huddle to verify elopement risk assessment accuracy, physician notification and preventative interventions in place as indicated. If discrepancies identified, immediate corrective action will be completed, and one on one education completed as indicated. 6. Residents identified with a change in elopement risk or who have had an actual elopement attempt will be reviewed during routine risk meeting by clinical interdisciplinary team. Review will be documented in the resident electronic medical record. 7. Routine elopement drills scheduled per community policy on varying shifts to confirm staff competency. 8. Findings of elopement drills are to be reported to the community Administrator and reviewed at the following morning meeting. If discrepancies are identified immediate correction will be completed and one on one education provided as indicated. Due to the corrective actions the facility completed prior to the onsite visit, the deficient practice was deemed past non-compliance and existed at a J scope and severity.

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 96 residents. The sample included 20 residents. Based on observation, interview, and record review, the facility failed to ensure the appropriate treatment and services to attain the highest practicable mental and psychosocial well-being of cognitively impaired Resident (R)53, who had a mental health disorder diagnoses, portrayed anger related to living in the facility, a history of exit seeking, and the facility staff did not respond to his suicidal ideation statements after his elopement (when a cognitively impaired resident leaves the facility without the knowledge or supervision of staff). On [DATE], R53 eloped from the facility. When staff returned R53 to the facility they placed a WanderGuard (a bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) on R53, and he reported he would never eat again. On [DATE] at 04:00 PM, R53 made statements such as give me a gun so I can shoot myself. At 10:00 PM, the resident reported he was being held against his wishes. On [DATE] at 11:30 AM, R53 reported he would not eat until someone came back to talk about him being discharged from the facility. An unidentified Staff told R53 it may be a while before someone could get to him as there are others in need of services. On [DATE] at 03:30 PM, staff found R53 had hung himself in his room with the TV cable on the closet door frame. This deficient practice placed R53 in immediate jeopardy. Findings included: - Review of the Electronic Health Record (EHR), documented R53 had diagnoses which included dementia (a progressive mental disorder characterized by failing memory and confusion) and bipolar (major mental illness that caused people to have episodes of severe high and low moods) and conduct disorder (a group of behavioral and emotional problems characterized by a disregard for others). The [DATE] Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. R53's total mood severity score of 00, indicated no depression. The MDS documented the resident did not have behaviors during the look back period. R53 was independent with all his activities of daily living (ADL). The [DATE] Behavioral Symptoms Care Area Assessment (CAA) documented R53 had episodes of agitation and anxiety and staff would proceed to care plan with continued monitoring and assistance as needed to avoid complications and minimize risks related to behaviors, with referral to physician and/or psychiatric services as needed. The [DATE] Quarterly MDS documented R53 had a BIMS score of nine, which indicated moderately impaired cognition. The MDS indicated no depression for the resident. R53 had become very anxious and agitated about why he was at the facility and when/why he could not go home for four to six days in the seven-day look-back period. R53 was independent with all his ADL. The [DATE] Care Plan documented an intervention, dated [DATE], indicating R53 was not allowed outside of the community, independently. Staff were instructed to provide redirection, diversion, and reorientation if R53 became restless, agitated, or exit seeking. The staff were to consult the physician if R53 was not easily redirected or had continued behaviors. The resident was an elopement risk/wanderer. R53 had an actual elopement from the facility. R53 had depression and anxiety and was on a daily psychotropic (alters mood or thought) medication for management, dated [DATE]. The staff would (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	monitor, record, and report to physician as needed for harm to self, suicidal ideation's, or refusal to eat or take medications. Review of the Progress Note revealed on [DATE] at 06:03 PM, R53 was upset about having to wait to get help to get out of the facility. R53 stated he was going to go, one way or another. The [DATE] Nurse Practitioner Note documented R53 required long term care placement in a memory care unit due to high elopement risk. Furthermore, R53 was upset to still be living in a nursing facility and had daily aggression. Review of the Progress Note revealed on [DATE] at 01:42 PM, R53 stated if he did not get dismissed, he would sneak out the back door at night. The Progress Note on [DATE] revealed: At approximately 07:15 AM, staff could not locate R53. At approximately 08:30 AM, the staff located R53 approximately two miles away from the facility. At 09:00 AM, Emergency Medical Services (EMS) transported R53 to the hospital for psychological evaluation and medical clearance after his elopement. At 03:00 PM, R53 returned to facility from the hospital. The staff placed a WanderGuard bracelet to R53's right wrist and placed R53 on one-hour checks for the next 72 hours. The Progress Note on [DATE] revealed: At 01:28 PM, staff found R53 at his window and when asked what he was doing R53 questioned when am I getting out of here? The WanderGuard bracelet was not on R53's wrist, it was located behind the TV in R53's room. The staff notified Physician Extender TT, who instructed staff to give R53 space to calm down and reapproach the resident in a few hours. At 02:30 PM, R53 continued to be adamant about leaving the facility and the staff contacted Administrative Nurse D. At 03:30 PM, Administrative Nurse D instructed staff to send R53 to the hospital for evaluation, per provider order. At 04:00 PM, staff informed R53 that EMS was on route to transport him to a hospital. R53 continued to make comments such as give me a gun so I can shoot myself. Staff were instructed to keep watch on the agitated resident. At 04:30 PM, R53 left the facility with EMS. At 10:00 PM, R53 returned to facility, aggravated that he was back, and with one-on-one in place at that time. The Progress Note on [DATE] at 06:39 PM, revealed the staff continued with one-on-one monitoring for R53 and the resident was verbally aggressive toward staff. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The [DATE] Physician Orders included an order for the Electronic WanderGuard bracelet (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) to be applied to R53, staff to validate the functioning every night shift. The Progress Note on [DATE] revealed: At 08:05 AM, Physician Extender TT updated on R53's continued aggressive behavior and refusal to take medications. Physician Extender TT recommended an inpatient psychiatric stay. At 08:25 AM, the facility nurse spoke to the hospital nurse, who suggested to send R53 to the hospital for evaluation. The Progress Note on [DATE] at 01:36 PM revealed the facility nurse spoke with the nurse at 11:00 AM and was informed R53 would be diverted to another hospital for admission to a Behavioral Health Unit (BHU). At 11:30 AM, EMS transported R53, who left willingly, however he stated, I will murder you if I have a reason too. The Progress Note on [DATE] at 05:20 PM, revealed R53 returned to facility, accompanied by EMS, with no new orders. The Progress Note on [DATE] at 11:30 AM, revealed R53 refused his lunch meal and stated he would not eat again until someone came back to talk to him about his dismissal. The staff advised R53 that it may be a while before someone could talk to him as there were others in need of services. R53 continued to stand at an exit door to watch staff enter the code to the door. The Progress Note on [DATE] at 02:37 PM, revealed staff noted a referral sent to a BHU at 11:15 AM due to increased behaviors. The BHU contacted the facility at 12:30 PM and informed them there were no beds available. The staff contacted a second behavioral unit and was informed there were no beds available. Staff sent a referral out to a third BHU at 02:41 PM, however, that unit staff stated the referral was not received and the referral was re-faxed. The Progress Note on [DATE] at 03:06 AM, revealed R53 continued one-on-one supervision. R53 remained in his room. The Progress Note on [DATE] at 10:02 AM, revealed the Administrative Nurse F assessed R53 for exit seeking behaviors. R53 was at baseline and staff would complete fifteen-minute checks for 24 hours. The Progress Note on [DATE] at 10:06 AM, revealed Administrative Nurse F assessed the resident and noted R53 continued at baseline and staff discontinued the fifteen-minute checks. Physician Extender TT's signed [DATE] Psychiatric Progress Note regarding the visit on [DATE] at 02:30 PM to 02:45 PM, documented R53 appeared disheveled, displayed irritable behavior, and had poor insight and impulse control. R53 remained focused on being released and became demanding and easily agitated. R53's conversation was tangential (different from or not directly connected with the one you are talking about) in nature, which further complicated the conversation and understanding R53's concerns. The staff reported R53's recent elopement and ongoing agitation and aggression. New order to increase on [DATE] at 12:45 PM, for R53's Quetiapine fumarate, 50 mg tablet to three times a day, for continued issues with mood and behavior. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Progress Note on [DATE] at 12:59 PM, noted R53 continued to ask for dismissal orders. The EHR lacked Progress Notes between the [DATE] at 12:59 PM and the [DATE] at 03:30 PM Progress Note. The Progress Note on [DATE] documented: At 03:30 PM, R53 was in his bed at 06:00 AM, with his eyes closed and breathing. At 08:00 AM, staff administered R53's medications and R53 asked staff when he was leaving. At approximately 11:30 AM, staff delivered lunch to R53 in his room. He asked how long he had been at the facility. At approximately 01:00 PM, R53 brought his lunch dish to the nurse's station. At approximately 03:30 PM, the staff found R53 hanging from his closet. The staff contacted the facility's management team. At 03:38 PM, Administrative Nurse D and Administrative Nurse F entered R53's room and found R53 hanging from the television cable on the closet door frame. The staff assisted R53 to the floor and began cardiopulmonary resuscitation (CPR- emergency lifesaving procedure performed when the heart stops beating). The staff called 911 and continued CPR. At 04:00 PM, EMS arrived and took over CPR. Social Service Designee contacted the guardian. At 04:05 PM, time of death was announced as EMS/Medical Coroner stopped all compressions per the guardian's request. Observation of the area, R53 would have presumably walked down was a residential area with a 35 miles per hour speed limit and R53 would have crossed 20 cross walks and crossed over two river bridges. Observation on [DATE] at 11:30 AM, revealed the memory care unit courtyard exit required a code to exit and enter. There was a six-foot wooden fence that surrounded the courtyard and attached to the building. There was a small alcove area that was near the exit door, not completely visible for staff to observe when they looked out the windows to the courtyard. During an interview on [DATE] at 11:38 AM, CNA Q reported R53 eloped in 2022, and she did not know when R53 had his WanderGuard removed after the elopement in 2022. CNA Q stated she had been educated previously to never let a resident outside by themselves in the courtyard. R53 had exit seeking behaviors as he would state he wanted to leave. CNA Q said the green patio chairs in the courtyard were removed after R53 eloped on [DATE]. She also confirmed she received education after R53 eloped in [DATE] and she received education about abuse, trauma, and suicide in July after the incident. During an interview on [DATE] at 02:26 PM, CNA MM stated R53 always asked him about being able to leave the facility. CNA MM stated that he received education about elopement, abuse, and trauma after R53 eloped on [DATE]. He also stated that R53 never made verbal comments of hurting himself and he had received training on suicide. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 02:26 PM, CNA NN stated R53 always asked about leaving the facility and wanted to live somewhere else. CNA NN stated he received education after R53 eloped, that included elopement, abuse, and trauma. He also stated that R53 never made verbal comments of hurting himself and he had received training on suicide. On [DATE] at 03:40 PM, Licensed Nurse (LN) I stated she could not locate R53 on [DATE] at approximately 07:15 AM and said CNA P last observed R53 in the courtyard. LN I stated she checked the sign-out book and confirmed R53 had not signed out of the facility. Staff could not locate R53 on the unit and contacted all staff on pager system and announced a Dr. Walker at approximately 07:30 AM. Administrative staff B located the resident at approximately 08:30 AM and brought him back to the facility. LN I confirmed R53 was very agitated about residing at the facility and his behaviors were almost daily. LN I was not sure if R53 had a previous elopement from the facility. LN I stated R53 was antsy and agitated and wanted to get out. She stated that R53 was placed on one-on-one observations 24 hours a day for about two weeks. LN I stated several staff members took turns with R53's one-on-one observation. LN I reviewed Physician Extender TT psychiatric progress note that was received on [DATE], however Physician Extender TT assessed R53 on [DATE]. LN I stated that Physician Extender would write new orders in the facility if needed and that waiting six days for new orders after a visit is not usual. LN I stated R53 was very agitated about being in the facility and never voiced any suicidal ideation's to her. LN I verified R53 had no progress notes charted in the EHR between the [DATE] at 12:59 PM progress note and the [DATE] at 03:30 PM progress note, when R53 was found hung in his room. LN I stated he was still wanting to leave but not as aggressive during that time period or a note would have been written, and stated the nurses' chart by exception. LN I also stated they do not chart notes on psych medications when changed, unless there was a concern. She stated the nurses would have to chart a lot on the residents, as psych medication changes occur often. LN I stated she had education for elopement, abuse, trauma, and suicidal ideation's signs and symptoms and to report concerns immediately to management. On [DATE] at 12:02 PM, LN G stated she was not at work the day R53 eloped from facility on [DATE]. She stated that she would not let a resident outside by themselves. LN G revealed that R53 was an exit seeker since the first day he admitted in December of 2022, and was not given a WanderGuard bracelet until after he eloped in December of 2022 shortly after he admitted to the facility. LN G could not recall when staff removed R53's WanderGuard bracelet. LN G stated that is not normal to receive new orders several days after a resident was seen by a provider. LN G stated that no progress notes were required after a medication change unless there was a concern. LN G stated she last saw R53 on [DATE] and he was his normal self. She confirmed that she received education after both incidents occurred, that included abuse, elopement, trauma, and suicidal ideation's and the facility had an elopement drill. On [DATE] at 03:00 PM, Administrative Nurse D stated that Physician Extender TT generally did not write orders in the facility when she assessed residents. Administrative Nurse D said Physician Extender TT would email to her all the signed progress notes with orders written on them if she wrote new orders. She stated it would take several days to receive the progress notes and orders back from Physician Extender TT and stated that was not acceptable. Administrative Nurse D confirmed that nurses generally charted when there was a concern. On [DATE] at 11:49 AM, Administrative Nurse F stated residents from the memory care units were not allowed to go outside in the courtyard or off the units independently. She stated R53 had always been an elopement risk and staff received education on abuse, elopement, suicidal ideation's and trauma. She stated that the facility tried to assist R53 to get admitted to a behavioral unit a few times (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and he would just be sent back from the hospital. The facility Suicide Threats policy dated 02/2021 documented if a resident made a suicidal threat, stay with the resident and immediately notify the nurse. The nurse would assess the resident and notify the Director of Nursing or designee and medical provider to establish a plan of care. The resident's environment would be evaluated, and potentially dangerous items removed. The interdisciplinary team would review documentations and behaviors and revise the plan of care. The facility failed ensure the appropriate treatment and services to attain the highest practicable mental and psychosocial well-being to cognitively impaired, R53, with known mental illness and anger related to placement in the facility, when staff failed to respond to his suicidal ideation comments after he eloped from the facility on [DATE]. This deficient practice placed R53 in immediate jeopardy, and R53 hung himself with a cable cord from his closet door. On [DATE] at 09:10 AM, Administrative Staff A and Consultant Staff SS were provided the Immediate Jeopardy (IJ) template and notified the facility failed to prevent the neglect of cognitively impaired, R53, with known mental illness and anger related to placement in the facility, when staff failed to respond to his suicidal ideation comments after he eloped from the facility on [DATE]. This deficient practice placed R53 in immediate jeopardy, and R53 hung himself with a cable cord from his closet door on [DATE]. The immediate jeopardy was determined to first exist on [DATE] at 06:00 AM, when staff left R53 unsupervised, outside on a memory care unit and he climbed a fence, left the facility, and was located approximately two miles away. The facility identified and implemented the following corrective actions, completed on [DATE] after R53's suicide: 1. An Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting held by interdisciplinary team on [DATE]. 2. The Administrator notified the Medical Director on [DATE] at 09:00 AM. 3. The [NAME] President of Clinical Operations re-educated the Administrator and Director of Nursing on community process for recognizing signs and symptoms of suicidal on [DATE]. 4. The Corporate Director of Clinical Reimbursement educated the Administrator, Social Service staff, and Director of Nursing regarding the community process of the social service comprehensive assessment and trauma informed care assessment. Education included intended scheduled, psychosocial care planning of 5. Current associates will be re-educated by the community by the Administrator or designee on or before [DATE] or prior to working next scheduled shift on community. Trauma Informed Care process with specific focus on identification of suicidal symptoms and suicidal ideation, required notifications and immediate actions. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. Social Service comprehensive assessments will be completed upon admission, annually and with significant change. Assessment will be documented in resident medical record. 7. Residents identified with need for trauma preventative services will have a trauma informed assessment completed upon admission, annually and with identified significant change in condition. Assessments will be documented in resident medical record. Care plan will be updated as indicated. 8. Routine angle rounds will be completed by assigned interdisciplinary team members routinely and will include staff members interviews to validate understanding of resident suicide awareness and notification requirements. Results of the angel rounds will be reported during routine morning stand up meetings. If discrepancies are identified immediate one on one educations will be completed with associate involved. 9. During weekly risk review meetings, the interdisciplinary team will review the clinical record of newly admitted residents or residents identified change in condition to validate completion of required social service assessments and or trauma informed care evaluations when indicated. The review will be documented in the resident medical record. 10. The Administrator or designee will routinely review sample selected residents for the next 60 days to validate compliance of the following: completion of the social service comprehensive assessment as appropriate, completion of trauma informed care assessment as appropriate, psychosocial care plan present when indicated that include resident specific interventions based upon assessment findings; any noted suicidal ideation as indicated. 11. Monthly review of completed weekly risk review and angle rounds results and trends will be completed by the Administrator or designee and reported to the QAPI committee for the next three months and then re-evaluate to determine if further monitoring is indicated. 12. Residents identified with a change in elopement risk or who have had an actual elopement attempt will be reviewed during routine risk meeting by clinical interdisciplinary team. Review will be documented in the resident electronic medical record. 13. Routine elopement drills scheduled per community policy on varying shifts to confirm staff competency. 14. Findings of elopement drills are to be reported to the community Administrator and reviewed at the following morning meeting. If discrepancies are identified immediate correction will be completed and one on one education provided as indicated. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 96 residents, that included 20 residents included in the sample. The sample included six residents for unnecessary medications. Based on observation, interview, and record review, the facility failed to ensure Resident (R)61's medication was available for administration without missed doses. This deficient practice placed R61 at risk of unnecessary complications from not receiving his medication, as ordered by the physician. Findings included: - Resident (R)61's Electronic Medical Record (EMR) documented diagnosis that included Human immunodeficiency virus (HIV is a virus that attacks cells that help the body fight infection, making a person more vulnerable to other infections and diseases). The admission Minimum Data Set(MDS) dated [DATE], documented R61 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The care plan, revised on 01/04/24, documented staff were to administer HIV medications as ordered. The physician's orders included Abacavir Sulfate- lamivudine, 600-300 mg, daily at bedtime, for HIV, ordered 09/26/24. Efavirenz, 600 milligrams, at bedtime, for antiretroviral, ordered 09/26/24. Review of the Medication Administration Record (MAR) from 06/01/24 to 07/31/24, revealed marked 5, indicated to see progress notes. However, the progress notes lacked notes related to why the medication was on hold. Review of the nurse notes on 07/30/24, revealed the resident was out of Efavirenz and Abacavir Sulfate-Lamivudine. Resident wants both medications taken together. Efavirenz was not available as it was on order. Staff told R61 that one of the medications was not available but may be delivered at midnight. On 07/30/24 at 11:28 AM, R61 reported he doesn't always get his medications as ordered. On 08/01/24 at 01:13 PM, Administrative Nurse D reported medications should be made available. Staff should check the medications, and if there was only a seven-day supply left, staff should reorder the medication. Staff should not wait until it runs low to be contacting the pharmacy. If the medication was on backorder from the manufacturer, staff should have contacted R61's physician for further guidance. Administrative Nurse D verified staff failed to notify the physician for further guidance when R61 was out of his medication. The facility's undated policy for Medication availability, documented refills ordered timely through the electronic health records (EHR) or by pulling stickers. Refills should be ordered when a 3-day supply of medication remain. Not all medications are auto received, must check and clear the Waiting to be Received queue in (computer software) Medication administration audit report run every day (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	during clinical meeting, follow up to be done immediately. If medication not available, staff to check emergency drug kit for medication, staff to call the pharmacy if the medication was not in the emergency drug kit, notify the director of nursing, and notify the practitioner. The facility failed to ensure Resident (R)61's medication was available for administration without missed doses. This deficient practice placed R61 at risk of unnecessary complications from not receiving his medication, as ordered by the physician.