STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465119	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Provo Rehabilitation and Nursing	1001 North 500 West Provo, UT 84604

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm 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** 6. Resident 310 was admitted to the facility on [DATE] and discharged on 3/27/24 with diagnoses which included sepsis, chronic respiratory failure with hypoxia, pneumonia, chronic obstructive pulmonary disease, cirrhosis of liver, muscle weakness and cognitive communication deficit. Resident 311 was admitted to the facility on [DATE] with diagnoses which included unspecified dementia, major depressive disorder, difficulty in walking and cognitive communication deficit. Resident 310 and resident 311 resided in the secured memory care unit. Resident 310's and resident 311's medical record was reviewed 10/7/24 through 10/21/24. Resident 310's MDS assessment dated [DATE], revealed a BIMS score of 1 which revealed severely impaired cognition. Resident 311's quarterly MDS assessment dated [DATE], revealed a BIMS score of 00 which indicated severe cognitive impairment. A Montreal Cognitive assessment dated [DATE], revealed a score of 3 out of 30 which indicated resident 310 had severe cognitive impairment. Resident 310's care plan dated 3/16/24, revealed At risk for impaired cognitive function/dementia or impaired thought processes r/t bims and phq9. The goal was Will maintain current level of cognitive function through the review date. Interventions included Administer medications as ordered; Communicate with family/caregivers regarding residents capabilities and needs; COMMUNICATION: Identify yourself at each interaction. Face when speaking and make eye contact. Reduce any distractions- turn off TV, radio, close door etc. Use simple, directive sentences. Provide with necessary cues- stop and return if agitated; Discuss concerns about confusion, disease process and alternative placement with family/caregivers; Keep routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion; and Monitor/document/report to MD any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465119	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Provo Rehabilitation and Nursing	1001 North 500 West Provo, UT 84604

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident 311's care plan dated 3/4/24 and revised on 5/23/24, revealed Potential for a behavior problem (Sexual Behavior/Affection towards Males) r/t Dementia - 2/28/24- sexual inappropriate behavior with resident #5315. Family consented. - 3/19/24 -sexually inappropriate Behavior with resident #5970 [resident 310]. Non consensual reported to Department of health services x 2 - 3/21/24- sexually inappropriate behavior with resident #5668 - 3/29/24- Sexually inappropriate behavior with Male Resident. Reported to necessary entities. 1:1 [one on one] Initiated during waking hours. -5/17/24-Titrating off of 1:1 per improved behavior, and IDT discussion - 5/23/24-Increased interest in Male Resident, inappropriate touching. Reported to necessary entities. 1:1 re-initiated during awaking hours. The goal was Will have fewer episodes of Behaviors by review date. Interventions included 1:1 during waking hours 3/29/2024; 3/19/24- review or adding medication by MD/NP to help with hypersexual behavior. Continue to monitor her wandering behavior and frequent checks; Administer medications as ordered. Monitor/document for side effects and effectiveness; Anticipate and meet needs; Approach in a calm manner; Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by; Document behaviors, and resident response to interventions; Frequent Checks r/t Wandering, Attempts to become affectionally/physically friendly with other male residents/staff 3/4/2024; If reasonable, discuss behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable; Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed; Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes; and Observe for side effects and adverse reactions of psychoactive medication:. Resident 311's progress note revealed on 3/4/24 at 9:54 AM ,Spoke with [family member] this morning about the incident. Family is aware that [resident 311] is a very touchy person, and the behaviors we observed during this incident are very common for her when she is comfortable with someone. Plan is to have [resident 311] approved on the NCW [New Choice Waiver] and move to AL [Assisted Living]. Resident 311's progress notes revealed on 3/19/24 at 1:00 PM, UA [urinalysis] results received. No organisms identified. Provider and family aware. Resident 310's progress notes revealed on 3/19/24 at 5:27 PM, Pt was seen by cna being hugged and kissed on the face and neck by female resident. CNA asked pt 1 [resident 310] if he wanted her to leave him alone, pt 2 [resident 311] was removed from situation and redirected to the day room. Resident 311's progress notes revealed on 3/19/24 at 5:15 PM, CNA noted that pt was kissing pt 2 on face and neck at the end of the hallway while sitting on the couch. Pt 2 was asked by cna if he wanted pt 1 to stop kissing him, pt 2 replied yes. CNA redirected pt 1 and walked with her to the day room. MD, DON, [NAME] in law [daughter in law], ADON notified. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465119	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Provo Rehabilitation and Nursing	1001 North 500 West Provo, UT 84604

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	A form 358 submitted to the State Survey Agency (SSA) dated 3/19/24 revealed there was an allegation of sexual abuse. The alleged victim was resident 311 and the location was in the memory care unit. The alleged perpetrator was resident 310. The allegation occurred on 3/19/24 at 5:15 PM. The detailed account of the incident revealed [Resident 310] was sitting in the family room watching television when [resident 311] walked past him several time. When she sat next to him she started to rub her hands along [resident 310's] legs and shoulders. As staff approached intervene, she began kissing his neck. The two were separated. The immediate steps taken to ensure residents were protected were When asked if he wanted [resident 311] to come back and sit by him, [resident 310] said 'no thank you' Residents are being kept separated for the rest of the shift and monitored. A typed of form with the investigation revealed a section actions taken were Complete investigation of allegations; Residents were asked to stay separated and monitored by staff; Staff education on maintaining distance between these two residents or having a chaperone present; and UA lab was conducted on [resident 311] to assess for a UTI [urinary tract infection] in hopes to explain her change in behavior. A form titled 359 that was submitted to the SSA revealed the conclusion of the investigation was Not Verified- Interviews with staff indicate that there was no intent to harm another resident, and no psychological harm was found after assessing both residents. Resident 311's progress notes revealed on 3/19/24 at 7:30 PM, Nurse saw resident lead resident 2 to a couch, and encourage them to sit down. Resident then kissed resident 2 on the neck and ran their hands down resident 2/s torso and groin, attempting to get their hands under resident 2's clothes. Nurse immediately told resident 1 to stop touching resident 2. Nurse immediately physically removed resident 1 from resident 2's vicinity and stopped 2 further attempts resident 1 made to touch resident 2. Resident 310's progress note dated 3/19/24 at 7:30 PM, Nurse saw resident was lead by resident 2 to a couch, and encouraged to sit next to them. Resident 2 then proceeded to run their hands down resident's torso and groin area, attempting to get their hands under resident's clothing. Nurse immediately told resident 2 to stop touching resident. Nurse immediately removed resident 2 from resident's vicinity, and stopped 2 further attempts made by resident 2 to touch resident. A form titled 358 that was submitted to the SSA on 3/20/24, which revealed sexual abuse was reported. The alleged victim was resident 310 and resident 311 was the alleged perpetrator. The incident occurred in the memory care unit. The detailed account of the incident was Nurse saw [resident 310] was lead by [resident 311] to a couch, and encouraged to sit next to her. [Resident 311] then proceeded to run their hands down [resident 310's] torso and groin area, attempting to get her hands under [resident 310's] clothing. Nurse immediately told resident 2 [resident 311] to stop touching resident. Nurse immediately removed [resident 311] from [resident 310's] vicinity. The steps taken immediately to ensure residents are protected was Residents are being closely monitored for interactions with each other and not allowed to be alone together. A form titled 359 that was submitted to the SSA revealed the allegation was Not verified - Interviews with staff indicate that there was no intent to harm another resident, and no psychological harm was found after assessing both residents. The corrective action taken was Completed investigation of allegations, residents were asked to stay separated and monitored by staff, staff education on maintaining distance between these two residents or having a chaperone present, a new medication was ordered in efforts to lower her libido. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465119	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Provo Rehabilitation and Nursing	1001 North 500 West Provo, UT 84604

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident 311's progress note revealed on 3/21/24 at 8:04 PM. patient continues to have sexual behaviors, staff found patient in another patients room in bed with a male resident standing next her with his hand in her brief and his pants down but brief still on patient were separated md don administer sister in-law notified. (Note: This incident occurred with resident 70.) On 10/17/24 at 3:53 PM, an interview was conducted with the DON. The DON stated anything potentially sexual in nature, staff should be reported to DON, Administrator, and Social Service Worker. The DON stated if a resident was not cognitively intact, then staff contacted the families to determine if the resident was able to consent to a relationship. The DON stated resident 311 was re-directed after the first interaction occurred on 3/19/24. The DON stated staff asked resident 310 if he wanted resident 311 removed and he said yes. The DON stated then there was a second interaction. The DON stated resident 311 was provided one on one until 3/29/24. The DON stated staff were completing frequent checks on resident 311 but there was no specific behaviors monitored or documented. The DON stated resident 311 did not have a specific residents she was targeting. The DON stated to protect other residents were safe from resident 311, included frequent checks initially and a UA on 3/18/24, to look for an underlying issues. The DON stated the UA was clear. The DON stated on 3/21/24, resident 311 was started on fluoxetine for her sexual behavior. The DON stated that resident 311 targeted everybody but not everybody wanted that. On 10/21/24 at 11:52 AM, a follow-up interview was conducted with the DON. The DON stated she did not know how residents had a second interaction on 3/19/24, with frequent checks in place. Based on observation, interview, and record review, the facility did not ensure that residents had the right to be free from abuse, neglect, misappropriation of property, and exploitation. Specifically, for 7 out of 69 sampled residents, residents were having consensual relationships per their families consent and the residents were not assessed and did not have the capacity to consent and residents were being sexually abused by other residents. Resident identifiers: 50, 70, 208, 209, 310, 311, and 409. Findings included: 1. Resident 70 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, chronic kidney disease stage 2, dementia, essential hypertension, mild protein-calorie malnutrition, dysphonia, history of falling, cognitive communication deficit, major depressive disorder, and fall on same level. Resident 70's medical record was reviewed from 10/7/24 through 10/21/24. A quarterly Minimum Data Set (MDS) assessment dated [DATE], documented that resident 70 had a Brief Interview for Mental Status (BIMS) score of 10. A BIMS score of 8 to 12 indicated moderate cognitive impairment. On 9/1/23 at 12:12 PM, a Nursing progress note documented Note Text : Pt [patient] found by OT [Occupational Therapy] in his room with his pants off and female resident sitting beside him on the bed. OT assisted pt in getting pants on and assisted pt to the dining room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465119	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Provo Rehabilitation and Nursing	1001 North 500 West Provo, UT 84604

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	On 9/1/23 at 12:39 PM, a Nursing progress note documented Note Text : CNA [Certified Nursing Assistant] found pt standing behind the curtain with female resident. CNA brought both pt out of the room and to the dining room for lunch. On 9/6/23 at 11:24 AM, a Nursing progress note documented Note Text : Patient is being friendly and having relations with another female resident on the unit. Family is aware and patient is his own power of attorney per nursing management pt is ok to continue relations. Pt was found in his room with pants down and female resident in room. Both parties are in agreement to the situation. Since then both patients have been separate on the unit per their own accord. No concerns at this time, will continue to monitor. A care plan Focus dated 9/18/23, documented RESOLVED: I have a special friend I like to spend time with. We like to hold hands and kiss but sometimes forget that others become uncomfortable when we're in in [sic] public areas displaying affection. - Displaying affection toward resident [resident 208]. He consented with the affection and resident [resident 208] son aware and no concern. - Huddle/Inservice to facility employee in the unit. The Interventions initiated on 9/18/23, included: a. Anticipate and meet needs. b. Approach in a calm manner. c. Assist to develop more appropriate methods of coping and interacting. Encourage to express feelings appropriately. d. Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by. e. If reasonable, discuss behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable. f. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. g. Provide a program of activities that is of interest and accommodates residents status. h. When displaying affection, staff to talk with parties involved to ensure all are consenting. On 10/10/24 at 4:58 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the resident associated with resident 70 during the incident on 9/1/23, was resident 208. The DON stated the incident was not reported because the incident was identified as a consensual relationship, between resident 208's family and resident 70 being his own power of attorney at that time. 2. Resident 208 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, Alzheimer's disease, essential hypertension, depression, and mild protein-calorie malnutrition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465119	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Provo Rehabilitation and Nursing	1001 North 500 West Provo, UT 84604

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident 208's medical record was reviewed from 10/7/24 through 10/21/24. An admission MDS assessment dated [DATE], documented that resident 208 had a BIMS score of 99 which indicated resident 208 was unable to complete the interview. On 8/29/23 at 4:50 PM, a Nursing progress note documented Late Entry: Note Text: Resident was found in male residents room sitting on bed. Redirected resident and male resident to join day room activities. Despite the redirection, both residents continued to hold hands and have physical contact. Residents were separated during dinner time. (Note: The incident was with resident 70.) On 8/30/23 at 3:49 PM, a Nursing progress note documented Note Text: NO [new order] from provider to initiate Lexapro r/t [related to] hypersexual behavior secondary to Alzheimers [sic], as well as Pepcid 20mg [milligrams] BID [twice a day]. NO in place, representative aware. On 8/30/23 at 4:52 PM, a Nursing progress note documented Note Text: Resident was found by CNA in male residents room. Male resident did not have any pants or brief on, and female resident had her shirt pulled up some. Resident was removed from male residents room. She was then taken to the shower room, her hospice CNA came to do cares on her. DON notified of happenings. CNA staff aware to keep residents separated. (Note: The incident was with resident 70.) On 9/1/23 at 12:11 PM, a Nursing progress note documented Note Text: Pt found in fellow residents room sitting on the bed. OT found pt this way and brought pt out of the room. (Note: The incident was with resident 70.) On 9/1/23 at 12:35 PM, a Nursing progress note documented Note Text: CNA found pt standing behind the curtain with fellow resident. CNA brought both patients out of the room for lunch. (Note: The incident was with resident 70.) On 9/6/23 at 1:39 AM, a Nursing progress note documented Note Text: Pt was found in another pt's bed at 0130 [1:30 AM]. She was in the same pt's room that had a res [resident] to res situation on 9/4 [23]. No issues today, the other pt calmly reported to nurse that she was in his bed and asked the nurse to help her to her room. (Note: The incident was with resident 70.) On 9/6/23 at 11:21 AM, Nursing progress note documented Note Text: Patient is being flirtatous [sic] with a male resident on unit. They hold hands and pt is often found in male patients room. Earlier male pt was found on his bed with pants down while [resident name redacted] was in the room with him. Patients family is aware and per nursing management family is ok with patients behavior with this one male patient only, if she is to take a liking to any other resident we must notify her family. After pt was found with the other resident in his room they've been separate on the unit per their own accord. Will continue to monitor. (Note: The incident was with resident 70.) On 9/18/2023 at 7:19 PM, a Nursing progress note documented Note Text : patient found kissing another male resident in the male residents room patient was redirected into an activity 30 min [minute] checks started. (Note: The incident was with resident 50.) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465119	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Provo Rehabilitation and Nursing	1001 North 500 West Provo, UT 84604

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	A care plan Focus created on 9/18/23 and initiated on 1/8/24, documented I have a special friend I like to spend time with. We like to hold hands and kiss but sometimes forget that others become uncomfortable when we're in in [sic] public areas displaying affection. - Resident displaying affection to resident [resident identifier redacted] and resident [resident identifier redacted]. - Son understand and aware of his mother affection with this resident. - Frequent Visual check and her whereabouts. - Huddle/Inservice staff q [every] change of shift to redirect resident. - Activities that catered to her needs to redirect her behavior. The Interventions created on 9/18/23 and initiated on 1/8/24, included: a. Anticipate and meet needs. b. Approach in a calm manner. c. Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by. d. If reasonable, discuss behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable. e. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. f. Minimize potential for resident's disruptive behaviors by offering tasks which divert attention. g. Provide a program of activities that is of interest and accommodates residents status. h. Staff to ensure when I am displaying affection towards others, that all parties are consenting. i. Stop and talk with resident when passing by. On 9/21/23 at 11:24 AM, an Interdisciplinary Team (IDT) progress note documented Note Text : IDT meet today unit managers/social worker and hospice to discuss about the incident that happened last 9/18/23. Resident was found kissing with resident [resident identifier redacted]. She wanders into his room, and both was redirected. Assisted resident back to activities and she stay in activities. Reported the incident to resident son and made aware. Hospice informed and plan to review her medication. Hospice plan to discuss with the son. Resident will be on q 30 mins [minute] checks and check her whereabouts. Plan activities that catered for her needs. Huddle with staff, Inservice about redirecting resident at all times. Continue as plan. Son aware and hospice informed. 3. Resident 50 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, dementia, vascular dementia, pain, essential hypertension, need for assistance with personal care, and cognitive communication deficit. Resident 50's medical record was reviewed from 10/7/24 through 10/21/24. A quarterly MDS assessment dated [DATE], documented that resident 50 did not have a BIMS score due to resident 50 rarely or never understood. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465119	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Provo Rehabilitation and Nursing	1001 North 500 West Provo, UT 84604

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	On 9/18/23 at 7:21 PM, a Nursing progress note documented Note Text : a female resident found kissing [resident name redacted] in his room the female resident was redirected into an activity 30 min checks started family attempted to call left message DON and MD notified. A care plan Focus initiated on 9/18/23, documented RESOLVED: I have a special friend I like to spend time with. We like to hold hands and kiss but sometimes forget that others become uncomfortable when we're in in [sic] public areas displaying affection - Displaying affection with resident [resident 208] and he likes the affection, and his family was aware and with no concern. The other resident family also aware with no concern - Huddle/Inservice the staff to Redirect the resident and made aware of the plan. The interventions initiated on 9/18/23 included: a. Administer medications as ordered. Monitor/document for side effects and effectiveness. b. Anticipate and meet needs. c. Approach in a calm manner. d. Assist to develop more appropriate methods of coping and interacting. Encourage to express feelings appropriately. e. Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by. f. Educate family/caregivers on successful coping and interaction strategies. Needs encouragement and active support by family/caregivers. Use these strategies. g. If reasonable, discuss behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable. h. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. i. Provide a program of activities that is of interest and accommodates residents status. j. When I am displaying affection towards others, ensure staff stop and ensure all parties are consenting. On 9/19/23 at 11:32 AM, a Social Services progress note documented Note Text : Spoke with PT niece today about incident of pt and other female resident kissing. Pt niece was understanding and consents for pt to have relations with another resident as long as he is happy. On 9/21/23 at 12:03 PM, an IDT progress note documented Note Text : IDT meet today. Clinical resource, Unit managers, SSD [Social Services Director] and SSD to discuss the incident that happened last 9/18/23. Resident was found kissing another resident [resident identifier redacted] in his room. Both was redirected. Reported this incident to resident niece and she was laughing because the resident already told her about it. No concern at this time. Will continue to monitor. NP [Nurse Practitioner] made aware of the incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465119	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Provo Rehabilitation and Nursing	1001 North 500 West Provo, UT 84604

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	On 10/16/24 at 11:37 AM, an interview was conducted with the Medical Director (MD). The MD stated that sometimes he was involved with the capacity to consent for residents but it would depend on the situation with the resident. The MD stated that he would get help from psychiatry if the residents were in and out or questionable. The MD stated if there was going to be something legally he would get more opinions. The MD state if the capacity to consent affected anything medical the facility staff would consult with him. The MD stated that he was not consulted on the interaction with resident 70 and resident 208. The MD stated if he was consulted he did not document on either of the residents. The MD stated if the resident had behavioral health services they would usually follow the resident and not him. The MD stated if the residents were on the dementia unit he would expect to be consulted. The MD stated if the resident had no cognitive impairment, diagnoses, disability, or a BIMS score that would have triggered the decision the residents should have the capacity to consent. The MD stated if the residents were on the regular unit and there was a question about capacity he might call in someone else. The MD stated that the residents had a personalized screening for consent. On 10/17/24 at 7:11 AM, an interview was conducted with the Social Worker (SW). The SW stated that he would do different cognitive assessments to determine if the resident had the capacity to consent. The SW stated if the BIMS score was questionable he would do a different more detailed assessment. The SW stated that he would assess if the residents understood and he would look at the residents orientation. The SW stated he would talk with the residents and do they understand what a relationship was and what that meant. The SW stated that residents had rights and they had the right to do what they want as long as it did not cause harm to others. The SW stated if the resident did not understand then he would talk with the family. The SW stated if the residents were both seeking each other he would call the family. The SW stated if the residents were not seeking each other the staff would put in interventions like staff would watch more and intervene. The SW stated if the residents wished to be together and hold hands that was fine but if the residents wanted more we would provide a private space. The SW stated if the other resident was not interested we would follow up with that party to make sure they were okay. The SW stated if the cognition was not there or the resident was on the Memory Care we would contact the family. The SW stated they would take into consideration the families opinion. The SW stated we would allow a companionship and it was all about safety. The SW stated when he met with the the residents he would document in a Social Services note. The SW stated that when the MD's or mental health did their rounds he would discuss the residents wishes with them. On 10/17/24 at 3:32 PM, an interview was conducted with the DON. The DON stated if the resident interactions had the potential to be sexual they would look at cognition and if cognition was not there they would contact the family to see if that was something that would be consensual on their end. The DON stated that until that was identified we would keep the residents separated and make sure the residents were safe and their interactions were done safely. The DON stated for the capacity to consent they would look a the residents BIMS score, diagnoses, involvement with social work, and involve therapy on determining those assessments. The DON stated the capacity to consent would be scanned in the residents medical record. The DON stated that resident 208's son stated that if resident 208 was happy he was happy, but of course the son wanted to keep resident 208 safe. The DON stated that staff were educated that resident 70's and resident 208's relationship was consensual but if it was more sexual to redirect them. The DON stated that snuggling or sitting on the couch was okay and it was more of a companionship. The DON stated that she felt the conversations with the family and redirecting of the residents that there was no need to report because it was not abuse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465119	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Provo Rehabilitation and Nursing	1001 North 500 West Provo, UT 84604

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	4. Resident 409 was admitted to the facility on [DATE] with diagnoses which included acute respiratory failure with hypoxia, pneumonia, [NAME]-Pick Disease Type C, fracture of neck of left femur, mild cognitive impairment, and acute kidney failure. Resident 409's medical record was reviewed from 10/7/24 through 10/21/24. A quarterly MDS assessment dated [DATE], indicated resident 409 had a BIMS score of 00 which suggested severe cognitive impairment. Per facility documentation, an incident of abuse between resident 409 and resident 209 occurred on 7/31/23. The following was documented: A Nursing Progress note, dated 8/1/23 at 2:02 AM, indicated, Male CNA reported that he went to check resident [409] bc [because] he was told he didn't have a brief. Upon entering the room he noticed that his roommate, resident [209], was looking at resident [409] and was up against resident [409]'s bed. Staff rediretd [sic] resident [209] back to his side of the room, closed the curtain and proceeded to assist resident [409] with his brief. Staff notice that there was a whitish discharge noted arouind [sic] penile area. After assisting resident [sic] [409] with brief he left the room and left the door open. Staff wentback [sic] a few minutes later to check on them and saw that the bedroom door was closed. He opened the door and saw that resident [209] was by resident [409]'s bed, touching him inappropriately with his hand on resident [409]'s genitals. He intervened and redirected resident [209] away from resident [409]. CNA reported incident to nurse and resident [209] was removed from room and placed into another unoccupied room in a different area of the unit. Incident reported to administrator, DON, ADON [Assistant Director of Nursing] and Provider. Review of the Form 358: Reported Incidents, dated 8/1/23 at 12:20 AM, for resident 409 documented, . [Resident 209] was witnessed by CNA [staff name redacted], at approximately 2215 [10:15 PM] near [resident 409's] bed inappropriately touching his genital area. CNA was reported to separate residents immediately and request assistance in residents shared room. The form further documented that resident 209 was moved to a private room with staff supervision and the police department and Adult Protective Services were notified. A Social Services Summary, dated 8/1/23 at 9:39 AM, indicated, Resident has experienced trauma this last week due to a roommate. IDT was held for Resident with daughter to see additional support needed. So far rt [resident] has not shown deference from baseline. Outside support has been offered and denied multiple times from [resident 409]. Referrals were made to [Behavioral Health Service] and NP so that they are available for help. Staff have states that [resident 409] has shown no emotions that are different then from before trauma. A Social Services Progress Note, dated 8/1/23 at 3:58 PM, indicated, PSYCHOSOCIAL ASSESSEMENT [sic]: Pt has limited ability to answer questions. He is able to answer yes and no as long as he is allowed time for response. Pt was asked questions about emotional and mental health. Pt has expressed sadness about the incident from night before. Pt acknowledges he is not angry just sad. Pt has acknowledged that he would like to see someone . A Nursing Progress note, dated 8/2/23 at 11:16 AM, indicated, Resident was visited by two [city name

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465119	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Provo Rehabilitation and Nursing	1001 North 500 West Provo, UT 84604

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 - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that each resident received adequate supervision to prevent accidents. Specifically, for 2 out of 69 sampled residents, a resident with cognitive impairment eloped from the facility memory care unit. In addition, a resident with cognitive impairment was moved out of the memory care unit and eloped from the facility. Resident identifiers: 50 and 70. Findings included: 1. Resident 70 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, chronic kidney disease stage 2, dementia, essential hypertension, mild protein-calorie malnutrition, dysphonia, history of falling, cognitive communication deficit, major depressive disorder, and fall on same level. Resident 70's medical record was reviewed from 10/7/24 through 10/21/24. On 3/18/23 at 9:35 AM, an Elopement/Wandering Evaluation documented that resident 70 was a Low Risk. On 3/23/23 at 7:54 AM, a Social Service Summary note documented [Resident 70] is admitted to facility for skilled nursing stay at this time. Pt [patient] was living at home with a person that recently moved in with him. Pt has one brother who is not support for him at all. The contact [name redacted] was a senior companion for him and his mother for while and is the only long term he helps. Pt needs 24 hour care due to cognition status. On 3/23/23 at 4:45 PM, a Nursing note documented Note Text : provided assistance with telehealth today with neurologist care taker was present neurologist discussed no concerns that he could see he advised if patient wants to continue to follow up with dementia dx [diagnosis] diagnostic or new dx (example parkinsons) he shouldfollow [sic] up with a general neurologist and he gave recommendations caretaker stated she would schedule and assist patient with the follow up, . On 4/5/23 at 1:28 PM, a Weekly Skilled Review note documented . Cognitive impairment makes discharge concerning, but wants to go home. On 4/13/23 at 9:51 PM, a Nursing note documented Note Text : Resident was observed walking hallway. Resident wandered in room [ROOM NUMBER] and that resident reported he appeared confused, and she called for the CNA [Certified Nursing Assistant] who helped him. Resident currently resting in bed with eyes closed. On 4/15/23 at 9:04 AM, a Nursing note documented Note Text : Alert charting r/t [related to] COC [change of condition]. Resident was recently found wandering into other residents room. Resident has had no recurring behaviors noted during this shift. Resident is alert and oriented per baseline. Vital signs are within normal limits. On 4/16/23 at 4:22 PM, a Nursing note documented Note Text : Alert charting ongoing to pt for wandered into another pt room. No episode behavior within shift noted. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465119	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Provo Rehabilitation and Nursing	1001 North 500 West Provo, UT 84604

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 - Few	On 4/16/23 at 7:34 PM, a Nursing note documented Note Text : Alert Note: On alert charting d/t [due to] wandering into room [ROOM NUMBER]. Was reported to this writer by the CNA that the family of the resident in room [ROOM NUMBER] told him that the resident had wandered into room [ROOM NUMBER] naked looking for the bathroom. At the time that the CNA was told of this the resident was in his own room. This was reported to management and the Physician. Will pass onto dayshift nurse. WCTM [will continue to monitor] resident for wandering throughout the shift. On 4/17/23 12:00 AM, an Encounter note documented . He has had some issues with wandering and going into peoples rooms, he will likely need the memory care unit for his safety. He reports to be feeling fair, denies any pain, nausea, or other complaints today. Neuro [neurological] - Alert, oriented x2 [person and place]. On 4/18/23 at 11:44 PM, a Nursing note documented Note Text : Resident observed waking in the hall by RT [Respiratory Therapist] and resident stated he just wanted to go sit down in the chairs at the end of the hall. CNA came out of a room observed the resident who told the resident he had been sleeping for three hours and wanted to go fora [sic] walk. When this writer observed resident, he was in his hospital gown which was open in the back had one shoe on and appeared confused he told this writer he was looking for a thing. On 4/19/23 at 12:49 AM, a Daily Skilled Note documented . Resident is Alert, Oriented X 1 [person] No Active Symptoms or Treatments effecting Level of Consciousness, Cognition, Sleep, Mood, or Behavior. Cognitive symptoms described as Alert with confusion. On 4/19/23 at 11:14 AM, a Nursing note documented Note Text : Pt moved from room [ROOM NUMBER] to room [ROOM NUMBER]. No problems with transfer. Provider and management aware. Social work aware. WCTM. (Note: Resident 70 was moved to the memory care unit that was locked.) On 6/18/23 at 9:35 AM, an Elopement/Wandering Evaluation documented that resident 70 was a Low Risk. A quarterly Minimum Data Set (MDS) assessment dated [DATE], documented that resident 70 had a Brief Interview for Mental Status (BIMS) score of 10. A BIMS score of 8 to 12 indicated moderate cognitive impairment. On 6/29/23 at 6:20 AM, a Social Service Summary note documented Social Service Summary : [resident 70] was moved into memory care due to wandering and disrobing after his skilled stay at facility. Pt has had an increased BIMS score since admission. Pt also had a diagnosis of UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITHOUT BEHAVIORAL DISTURBANCE, PSYCHOTIC DISTURBANCE, MOOD DISTURBANCE, AND ANXIETY with a history of strokes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465119	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Provo Rehabilitation and Nursing	1001 North 500 West Provo, UT 84604

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 - Few	On 8/20/23 at 3:28 PM, a Nursing note documented Note Text : At approximately 1435 [2:35 PM] the pt's brother asked the nurse where the pt is. The nurse asked the brother if he had already checked the pt's room/bathroom as he can usually be found in there and the brother said he was not in there. At this point the nurse and the pt's brother set out to find the pt. Pt was not found in the main dining hall where church was being held. The nurse asked the CNAs if they had seen the pt, one said she thought he might be at church and another one said he had been let out to spend some time outside in front of the building, which others had apparently seen him do on previous occassions [sic]. One cna took her car out driving around the facility searching for the pt. The nurse and pt's brother continued to walk around inside and outside the facility looking for the pt. While looking outside one of the facility's transport staff told the nurse that he had received a call about the pt being found and was on his way to get him. Once returned to the facility, the nurse assessed the pt before the pt's brother took the pt out for their dinner appointment. Neuros [neurological] started since the fall was unwitnessed. On 8/20/23 at 9:25 PM, a Nursing note documented Note Text : On monitoring for elopement, frequent checks done. safety precautions in place. all needs anticipated and met. call light within reach for assistance. will cont [continue] to monitor. On 8/25/23 at 7:45 PM, a Fall Committee Interdisciplinary Team (IDT) note documented LATE ENTRY Note Text : DON [Director of Nursing] and PT [Physical Therapy] present during review on 08/25/2023. Most recent fall risk assessment conducted 08/20/2023, with a score of 9, indicating resident is a medium fall risk. Most recent fall recorded 08/20/2023, fall was unwitnessed and did not result in any injuries. New interventions include; re-assess elopement risk and education to staff on memory care unit policy and procedure. Exhibit Form 359 submitted to the State Survey Agency documented on 8/21/23 at 12:00 PM, The resident was friendly and simply stated he was bored and wanted to go outside. The resident stated that he also was trying to go see his brother in Springville. I asked him if he was happy here, he said yes. The resident said he feels safe and liked living here. On 8/21/23 at 11:00 AM, CNA 2 was interviewed by a staff member [CNA 2] was the staff member that opened the door and let [resident 70] leave. While speaking with her, she said that he simply asked to go outside, and she let him out. She claims that she has seen him outside of the memory care unit before, as well as the courtyard outside. So she didn't think it was an issue letting him out. After some education, she expressed remorse in allowing him outside unsupervised, and stated that she should have checked with the floor nurse. On 10/10/24 at 11:00 AM, an interview was conducted with CNA 1. CNA 1 stated that she was not aware of any residents that were able to go outside unattended and she had never seen any resident go outside unattended. CNA 1 stated she had worked at the facility since September 2024. CNA 1 stated if a resident wanted to go outside she would ask the nurse or tell the nurse to let them know who she was taking outside. CNA 1 stated that she would stay outside with the resident. CNA 1 stated the smoking area was secured and if a resident was left out in the smoking area they would not be able to get out. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465119	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Provo Rehabilitation and Nursing	1001 North 500 West Provo, UT 84604

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 - Few	On 10/17/24 at 3:36 PM, an interview was conducted with the DON. The DON stated that resident 70's brother had come to the facility to take resident 70 out and that was not uncommon. The DON stated that resident 70's brother came in looking for resident 70 and the nurse was unsure where resident 70 was and starting looking for him. The DON stated as staff were outside the transportation called to tell them they found resident 70 and they were on the way to get him. The DON stated they would determine if a resident needed to be on the unit by looking at their previous elopement history, reports from the hospital, wandering or exit seeking in the facility, and they would discuss with the family proper placement. The DON stated the elopement assessment contained resident cognition, elopement history, and statements wanting to go home. The DON stated that resident 70 was noticed missing at 2:35 PM. The DON stated a bystander called that resident 70 had fallen in the grass a couple blocks away. The DON stated CNA 2 reported she had seen resident 70 up front outside before and thought it was okay to let him out. The DON stated that education was provided to CNA 2 to clarify if a resident on the secured unit could go out. The DON stated CNA 2 was a newer employee. The DON stated when resident 70 had been outside in the past it had been with recreation therapy. The DON stated they were using consistent staff on the unit and a therapist had a desk on the unit and was on the unit daily. 2. Resident 50 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, dementia, vascular dementia, pain, essential hypertension, need for assistance with personal care, and cognitive communication deficit. Resident 50's medical record was reviewed from 10/7/24 through 10/21/24. A quarterly MDS assessment dated [DATE], documented that resident 50 did not have a BIMS score due to resident 50 rarely or never understood. On 11/7/23, the Elopement Wandering Evaluation documented that resident 50 was a high risk for elopements. On 12/12/23 at 1:47 PM, a Nursing note documented Note Text : IDT discussion on moving resident off of unit d/t todays incident, as well as lack of exit seeking behavior. Resident is observed to wander aimlessly at times but is not exit seeking. Discussed plan to move resident today to room [ROOM NUMBER]A with IDT and resident Niece [name redacted]- Niece approves of room change and will be coming to see him at the facility today. On 12/12/23, resident 50 was to room [ROOM NUMBER]-A. (Note: Resident 50 was moved to room that was not on the secured unit.) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465119	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Provo Rehabilitation and Nursing	1001 North 500 West Provo, UT 84604

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 - Few	On 12/24/23 at 3:42 PM, a Nursing note documented Note Text: Resident was seen at apx [approximately] 1245 [12:45 PM] after lunch today walking with walker towards 400 hall. Nurse could not locate resident about 10 minutes later and began looking. Staff and management notified when resident could not be found. Staff looked in all rooms, outside around building and neighborhood. Nurse attemped [sic] multiple times to contact family but unable to reach anyone. Nurse called police to report resident missing. Dispatch stated that a call was made about a man outside near our building. [Name redacted] fire dept [department], ambulance, and police were seen near [name redacted] underground parking. Nurse ran over to [name redacted] with dispatch on the phone. Resident was found with police and EMTs [Emergency Medical Technicians]. EMTs reported that he may have fallen, bystanders helped him to the side of the parking garage and called police. EMTs reported that all VS [vital signs] were wnl [within normal limits], resident appeared unharmed upon assessment. A small scrape to right knee is the only skin alteration nurse noted. Nurse and EMTs brought resident back to facility in ambulance. Resident was immediately returned to 100 Hall locked unit. Will have new placement in rm [room] 103. Neuro's started on resident on 100 Hall. VSS [vital signs stable], resident happy to be back. On 12/28/23 at 4:41 PM, a Nursing note documented Note Text : patient has been wandering hallways on memory care unit. He has entered rooms that are not his. He got upset at a cna for redirecting him out of a female residents room. He is currently in a room that is not his but is unoccupied. He does not want to go to his own room and doesn't show any reason to dislike his current room. He just seems to be confused and wandering. Otherwise no issues noted. Will continue to monitor On 2/21/24 at 11:25 PM, a Nursing note documented Note Text : Alert charting. Patient is struggling with the room move and is not happy with it. He was seeking to elope and asked staff to unlock the door. He is adamant that he is leaving and is complaining about his roommate not sleeping. On 2/25/23 at 11:57 AM, a Nursing note documented Note Text : resident and family notified of room change and was agreeable to room change today resident moved with all belongings room updated in chart. On 10/17/24 at 3:49 PM, an interview was conducted with the DON. The DON stated that resident 50 had admitted to the unit initially due to cognition and elopement risk. The DON stated that resident 50 was no longer exit seeking so staff thought it was appropriate to move resident 50 off the unit. The DON stated at 12:45 PM, after lunch resident 50 was walking the back side of the hall and 10 minutes later the nurse could not locate resident 50. The DON stated that staff did a search of the building, contacted the family, called the police department, and dispatch reported they might have located resident 50.