STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265330	A. Building B. Wing	10/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Village Park	2041 Silva Lane Moberly, MO 65270

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** 32530 Refer to Event ID 9L9W13. Based on observation and interview, the facility failed to identify and implement interventions to address one resident's (Resident #502) history of taking other residents' personal items, resulting in failure to protect one resident (Resident #541) from physical abuse. Resident #502's roommate (Resident #541) reported to staff that Resident #502 had his/her clothing and was a thief. Staff did not intervene. Resident #541 later became agitated with Resident #502 for taking his/her clothing. Resident #502 hit Resident #541 in the head with a bedside table, resulting in a laceration to Resident #541's head that required medical intervention, including five sutures. The facility census was 152. The administrator was notified of the past non-compliance which occurred on 8/4/21. On 8/4/21, the administrator became aware of the violation. The facility immediately separated the residents and placed Resident #502 on one-on-one observation until he/she was transferred to the hospital for evaluation and was discharged The facility transferred Resident #541 to the hospital for medical treatment. The facility notified the state agency and the police department and conducted an investigation. The non-compliance was removed and corrected on 8/4/21. Review of the facility's policy, Abuse, Neglect, Grievance Procedures, dated 11/28/16, showed the following: -It is the policy of the facility that every resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. It is also the policy of this facility that every resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion; -Mistreatment, neglect, or abuse of residents is prohibited by this facility; -This facility is committed to protecting our residents from abuse by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals; (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Actual harm Residents Affected - Few	-The facility abuse prohibition program included screening, training, prevention, identification, reporting/investigating, and protection of the resident. 1. Review of Resident #502's Preadmission Screening and Resident Review (PASRR, a federally mandated screening process to help ensure individuals are not inappropriately placed in nursing homes for long-term care), dated 10/3/17, showed the following: -Symptoms include physically threatening behavior and increased irritability posturing in threatening manner with staff/peers; -The resident had difficulty concentrating/holding a conversation and impaired judgment/insight; -Current symptoms include mumbled delusional statements, mild irritability, and sneaking sandwiches from peer's tray; -Problematic behaviors include cursing and swearing, seclusiveness and suspicious of others; -Client required staff supervision during meals to assure he/she is not taking food off other client's trays; -Client has lengthy history of severely disorganized thought process, verbalizations, behavior, speaks in word salad (a jumble of extremely incoherent speech) most of the time, paranoid/grandiose ideation, threats/posturing (intent to inflict harm) to harm others, response to internal stimuli; -Individual does not present an imminent danger to self or others at this time; -Provide reduced stimulation if irritable, do not push the client, but allow time for him/her to reconsider requests, monitor for worsening psychotic symptoms, threatening stance when client does not wish to comply with requests; -If client assumes threatening posture, redirect inappropriate behaviors, allow time to calm down before approaching to discuss; -Client had recent changes in behavior in which he/she became verbally aggressive with physical posturing toward staff; -A secured facility is recommend to assure client does not wander away due to level of disorientation. Review of the resident's care plan dated, initiated 11/5/19, showed the following: -Per PASRR, the resident had multiple hospitalization s related to mental health diagnosis. The resident had history of delusions (he/she is the president), hallucinations, word salad, non-compliant with cares, treatments, medications, disorganized thought process, self-harm, physically threatening behavior, and refuses activities of daily living (ADL) and to change clothing; -Provide the resident with one-on-one time to vent and verbalize feelings and concerns related to past and present life experiences as needed; (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-The resident has impaired thought processes. He/She has disorganized thinking and difficulty forming sentences and nonsensical at times; -Approach the resident in a warm, positive, and calm manner; -Calmly talk with the resident and always explain what you will be doing before you do it; -Monitor and document behavior as needed; -Ongoing assessment for changes in mental status, behavior emergencies, and impaired cognitive functioning; -The resident has manifestations of behaviors related to his/her mental illness that may create disturbances that affect others. These behaviors may include taking food from others trays, verbal aggression, delusions, and confusion; -Assist the resident with the root cause of change in behaviors or mood as needed. Give positive feedback for good behavior. If the resident is disturbing others, encourage him/her to move to a more private area to voice concerns/feelings to assist in decreasing episodes of disturbing others; -Non-pharmacological interventions include: meet with administration/staff member that he/she was comfortable with, encourage him/her to watch television, provide one-on-one time, and encourage appropriate socialization. Review of the resident's quarterly Minimum Data Set (MDS), a federally required assessment, dated 5/29/21, showed the following: -Diagnoses included schizophrenia (a disorder that affects a person's ability to think, feel and behave clearly); -Unclear speech, slurred or mumbled words; -Usually understood and usually understands others; -Memory was not assessed; -Physical behaviors directed towards others occurred one to three days (in the seven-day look back period); -Verbal behaviors directed towards others occurred one to three days; -Other behaviors not directed towards others (such as hitting scratching self or rummaging) occurred one to three days; -Independent with walking, dressing, eating, toilet use and personal hygiene; -Steady with walking and no device required. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's care plan, dated 6/4/21, showed the resident was involved in an altercation with a peer where he/she attempted to take a mug belonging to his/her peer causing the peer to become agitated. (Review of the resident's care plan showed no evidence staff evaluated current interventions or implemented new interventions after the resident attempted to take another resident's mug.) Review of the resident's nurse's note, dated 8/4/21 showed at 10:15 A.M., a code green was called related to resident-to-resident altercation. The resident and his/her roommate were verbal related to the resident having his/her roommate's (Resident #541) pants. Resident #541 asked for his/her pants back and Resident #502 threw his/her bedside table at Resident #541. Both were immediately separated. Resident #502 was placed one-on-one for protective oversight at this time. Review of the resident's care plan, dated 8/4/21, showed the following: -Resident #541 reported the resident took his/her pants. When Resident #541 attempted to get his/her pants back, the resident (Resident #502) picked up the bedside table and threw it at him/her; -Upon investigation, the facility believed the resident pushed the bedside table to get Resident #541 away from him/her, and it struck Resident #541 in the face causing injury; -The resident was placed on one-on-one monitoring and sent out for medication evaluation to ensure protective oversight. Review of the facility's investigation, dated 8/4/21 at 6:00 A.M., showed the following: -Staff heard a commotion on the hall and responded to the room. Upon entering the room, staff observed Resident #541 with a cut above his/her eye and on his/her cheek. Resident #541 reported his/her roommate (Resident #502) picked up his/her bedside table over his/her head and threw it at him/her. Resident #541 did change his/her story and said that maybe he/she didn't pick it up over his/her head. The resident may have picked it up at a 45 degree angle at him/her. Resident#541 also said he/she was asking for it, and he/she brought it on himself/herself. Resident #541 said the resident took his/her pants earlier in the week and he/she was trying to get his/her pants back. Resident #541 reported he/she followed Resident #502 and asked if he/she wanted to go. A skin assessment was completed and Resident #541 had a laceration (cut) above the left eye and a scrape on the left cheek. Neurological checks (an assessment completed after a head injury) were initiated. Resident #541 was sent out for evaluation. Resident #502 refused to give his/her statement, but does not have any history of physical aggression. Resident #502 was placed on one-on-one for protective oversight and then sent out for medication evaluation; -The staff reported they did not witness the altercation, but said Resident #541 said his/her roommate (Resident #502) was a thief, and he/she wanted to meet with the administrator when he/she arrived. Staff said they would let the administrator know. The resident verbalized understanding and did not verbalize any other concern to staff. The guardians, police and the administrator were all notified. Review Resident #541's care plan, revised on 8/4/21, showed the following: (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-On 8/4/21, the resident reported a peer took his/her pants. When the resident attempted to get his/her pants back, the peer picked up a bedside table and threw it on him/her; -Upon investigation, the facility feels the peer pushed the bedside table to get Resident #541 away from him/her, and it struck Resident #541 in the face causing injury; -Resident #541 was sent to hospital for evaluation. Review of the resident's hospital discharge instruction, dated 8/4/21 at 6:46 A.M., showed the following: -Diagnosis: Laceration (cut) without foreign body of the other part of the head; -Follow-up instructions: As need for staple/suture removal; -Five stitches needed. Remove in seven to ten days. Review of the resident's quarterly MDS, dated [DATE], showed the following -Cognition intact; -Diagnoses included schizoaffective disorder (a mental health condition symptoms may include delusions, hallucinations, depressed episodes and manic periods of high energy), Parkinson's disease (a disorder of the central nervous system that affects movement often including tremors), traumatic brain injury (a violent blow to the head) and depression; -No behaviors exhibited; -Required supervision and setup with transfers; -Ambulation did not occur; -Mobility device used was wheelchair. During interviews on 9/29/21 at 11:10 A.M., and 10/1/21 at 10:10 A.M. and at 3:20 P.M., Resident #541 said the following: -The morning before Resident #502 hit him/her in the head with the bedside table, Resident #502 was in Resident #541's side of the closet, because Resident #502 didn't have any clean pants; -He/She hit his/her call light and the nurse got Resident #502 out of his/her closet; -The next day, Resident #502 had on a pair of Resident #541's pants; -He/She told Resident #502, you have the wrong pants on! -He/She chased Resident #502 down the hall to the dining room and back to their room; (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-He/She told Resident #502 to get his/her pants off, and Resident #502 said he/she was a lying bastard; -He/She asked Resident #502 if he/she wanted to go (fight); -Resident #502 picked up a bedside table and hit him/her on the side of the head with the metal portion of the table; -He/She had to go to the hospital for sutures (stitches); -He/She was very angry when Resident #502 had his/her pants on, a family member had given him/her the pants, and that family member had since passed away. During interview on 10/1/21 at 10:10 A.M. Resident #157 said the following: -Resident #502 had taken clothes from his/her roommate (Resident #541) before; -The staff tried to get Resident #502 to give him/her clothes back, but he/she just ignored them (this happened prior to the altercation on 8/4/21); -Resident #502 was seen wearing Resident #541's pants and a purple, Nike shirt in the hall (prior to the 8/4/21 altercation). During interview on 10/1/21 at 2:20 P.M., Certified Nurse Assistant (CNA) H said the following: -He/She was out with the residents on smoke break on the morning of 8/4/21; -CNA L told him/her Resident #541 thought Resident #502 had his/her pants; -Resident #541 was smoking at this time, and didn't seem upset; -He/She didn't report anything to the nurse; he/she thought CNA L reported it; -Later he/she heard a boom, and Resident #541 was found bleeding in his/her room. The bedside table was knocked over and Resident #541 said Resident #502 threw the bedside table at him/her. Review of CNA L's statement, provided by the facility, dated 8/4/21, showed the following: -CNA L was at the nurse's station and heard yelling. CNA L and CNA H went into Resident #502 and #541's room. Resident #502 was yelling, CNA L went to escort Resident #541 out, while CNA H tried to talk to Resident #502; -CNA L noticed Resident #541 was bleeding. Resident #541 said he/she got the table thrown at him/her. When CNA L looked at the table, it was upside down; (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Addendum via phone call on 8/4/21 at 9:11 A.M.: Prior to the incident, at the 6:00 A.M. smoke break, Resident #541 said Resident #502 was a thief. Resident #541 thought Resident #502 had a pair of his/her jeans and was going through his/her closet. Resident #541 said he/she wanted a room change and wanted to talk to the Administrator when she arrived. During interview on 10/1/21 at 10:12 A.M., CNA J said the following: -Resident #502 was known to take clothes from other residents. He/She had found Resident #502 in other residents' closets going through their things; -He/She had redirected him/her and told the nurse in charge. -He/She was not sure what was done about it. During interview on 10/1/21 at 3:30 P.M., Certified Mediation Technician (CMT) K said the following: -Resident #502 often took things that were unattended or belonged to someone else; this was Resident #502's baseline (or common behavior for him/her); -The resident took soda, food, and about anything from staff or residents; -The residents would get upset because Resident #502 took their things; -The staff would remind the other residents that Resident #502 did this and to not leave items unattended; -Staff tried to redirect the resident, but he/she continued to take items. During interview on 10/121 at 9:50 A.M., Licensed Practical Nurse (LPN) I said the following: -Resident #502 had issues with taking other residents' things; -He/She could recall four or five residents who had accused Resident #502 of taking things from them in the past; -He/She didn't recall anything that was done differently after it occurred; maybe to monitor Resident #502 to ensure he/she wasn't taken things from others. -The resident didn't have a history of being physically abusive with others. He/She often yelled out for no reason, he/she would say things like, get the hell out of my way! During interview on 10/1/21 at 2:05 P.M., the Director of Nursing said the following: -Resident #502 was very specific about his/her clothing and he/she could not see him/her taking clothes from another resident; (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Resident #502 might have taken food in the past or grabbed something off of another resident's table, but he/she wasn't aware of him/her taking clothes from other residents; -If he/she was taking food, he/she could potentially take other items from residents; -He/She wasn't aware the resident had a history of taking clothing from other residents. During interview on 10/1/21 at 2:00 P.M. and 2:35 P.M., the Administrator said the following: -Staff notified her around 6:00 A.M. the morning of the altercation (8/4/21) that Resident #541 said his/her roommate was a thief, and he/she wanted to talk to the Administrator when she arrived to the facility; -Nothing was mentioned about Resident #541 being upset at that time; -She informed staff she would meet with Resident #541 when she got to the facility; -She planned on talking to the resident when he/she got to the facility, however, the altercation took place prior to her arriving; -Neither resident had a history of physical aggression, -Resident #502 had different roommates in the past, and there were no complaints about him/her being in their closets or taking things; -She had no knowledge that Resident #502 was ever found in another resident's closet; -If staff were aware of this, it was not reported to her; -She would have expected staff to report it to her. MO00189020

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - 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** 32530 Refer to Event ID 9L9W13. Based on observation, interview, record review, the facility failed to provide protective oversight to ensure one resident (Resident #501), who had a history of elopement and was identified as a risk for elopement, did not leave the facility without staff's knowledge. The resident resided on a secured unit. Staff were to perform face checks for safety, which included observing the resident every 30 minutes to acknowledge his/her whereabouts. On 9/26/21 and 9/27/21, staff failed to perform face checks as directed, and were unaware the resident left the facility at an unknown time prior to 9:30 P.M. through his/her bedroom window. The resident met a taxi at a gas station at 9:30 P.M. and obtained a ride to a park in city located approximately 40 miles from the facility. Staff identified the resident was missing on 9/27/21 at approximately 4:00 A.M. when a laboratory representative went to obtain a blood sample from the resident and was unable to locate the resident in his/her room. The facility census was 152. The administrator was notified of the Past Non-Compliance which occurred on 9/26/21. On 9/27/21, the administrator became aware of the violation. The facility completed the following to correct the violation: -Face checks were completed on all residents immediately after staff realized the resident was missing; -Staff members who failed to perform face checks on the evening of 9/26/21 and morning of 9/27/21 were immediately placed on suspension as a result of their failed intensive monitoring per facility policy; -All staff were in-serviced immediately on the facility's intensive monitoring policy, hall assignments, and walking rounds; -All residents residing on secured unit where the resident resided were assessed for elopement precautions to ensure that appropriate residents resided on that unit; -The facility added a night supervisor who would be scheduled from 7:00 P.M. until 7:00 A.M., seven days a week. He/She would ensure staff completed face checks would be completed and the building would be monitored continuously; -Facility implemented Mock Code [NAME] (missing resident) drills three times a week for two weeks then would conduct them weekly after that; -Facility implemented department heads coming in at random times to conduct spot checks to ensure the system was being followed; -An audit was completed on face check documentation in the electronic health record program to ensure all residents in the facility were assigned appropriate timed face checks; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Random face check observations were made by management team. Review of random spot check documentation showed staff were completing face checks as per policy and if there was any concerns, staff were educated at the time of the random check. The non-compliance was removed and corrected on 9/28/21. Review of Resident #501's Pre-admission Screening for Mental Illness/Mental Retardation or Related Condition (PASRR), dated 3/31/21, showed the following: -His/Her diagnoses included alcoholism, major neurocognitive disorder due to alcohol induced dementia, paranoid schizophrenia (long-term mental disorder involving a breakdown in the relation between thought, emotion, and behavior, leading to faulty perception inappropriate actions and feelings, withdrawal from reality, and personal relationships into fantasy), and impulse disorder (condition in which a person has trouble controlling emotions and behaviors and often violate the rights of others or conflict with societal normal and the law); -He/She required monitoring due to exit seeking behaviors; -He/She had increased agitation at times that required redirection. Review of resident's modified PASRR, dated 4/7/21, showed the following: -He/She was transferred from another facility on 4/1/21 for increased aggression and attempting to elope. He/She made threats to hit people and had threatened that he/she would get out of the nursing home and kill his/her spouse; -He/She was hospitalized in January 2021 after he/she made elopement attempts, threatened to elope from facility and kill his spouse; -He/She was irritable and grouchy; -He/She had behavioral disturbances, delusions, memory impairment, forgetfulness, and confusion; -His/Her behaviors included elopement/left facility; -He/She required physical assistance with maintaining personal safety and going outdoors safely; -He/She did not make good decisions; -He/She had a diagnosis of dementia, exhibited memory impairment, and a disturbance in executive functioning; -Recommendations were for continued outpatient psychiatric follow up/consults and placement in a secured behavioral unit with elopement precautions. Review of resident's nursing admission summary, dated 4/1/21, showed the resident was at risk for elopement due to previous attempts to leave at a previous facility. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident's elopement risk evaluation, dated 4/1/21, showed the following: -He/She had a history of elopement or had attempted to leave the facility without informing staff; -He/She had verbally expressed the desire to go home, packed belongings to go home, or stayed near an exit door; -He/She was considered at risk for elopement; -Clinical suggestions included frequently monitoring his/her location, utilization of exit alarms and check in/check out logs, and notification to staff of elopement risk. Review of resident's care plan, dated 4/1/21, showed the following: -Per PASRR, he/she was deemed to be safe for admission to the skilled facility; -He/She was at risk for elopement related to history of elopements and voiced desire to leave the facility and kill his/her spouse; -He/She had diagnosis of alcohol induced dementia with behavioral disturbances and was to remain in the facility for safety reasons; -Goal: He/She would remain safe in skilled nursing facility; -Facility would remain locked down at all times for safety precautions; -Nurse and certified nursing assistant (CNA) to complete face checks for safety. Review of the facility's census report, dated 4/1/21, showed the resident was admitted to a room located on a secured unit. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment to be completed by facility staff, dated 4/8/21, showed the following: -He/She was admitted on [DATE]; -His/Her cognition was moderately impaired; -He/She was independent with activities of daily living (ADLs); -He/She had not exhibited any wandering behaviors in the previous seven day look back period. Review of resident's nursing progress note, dated 4/21/21 at 5:22 P.M., showed the resident was banging on the windows and hitting the TV in an attempt to break them. He/She was placed on one-on-one observation. He/She expressed that he/she wanted to go to jail so he/she could just do his/her time and get out, rather than being there without an out date. (The resident was sent to the hospital for psychiatric evaluation and treatment). (continued on next page)

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	265330	A. Building B. Wing	10/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Village Park	2041 Silva Lane Moberly, MO 65270

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's census sheet, dated 5/4/21, showed the resident was readmitted to the same room on the secured unit. Review of the resident's elopement risk assessment, dated 5/5/21, showed the following: -He/She was at risk for elopement; -Staff were notified of the resident's elopement risk; -The resident's location was to be frequently monitored; -Utilization of exit alarms and check in/check out log. Review of the resident's quarterly MDS, dated [DATE], showed the following: -His/Her cognition was intact; -He/She exhibited no psychosis, wandering behaviors, or rejection of care in the previous seven day look back period. Review of the resident's progress notes, dated 7/14/21 at 3:15 P.M., showed a care plan meeting was held with his/her guardian. The guardian reported the resident would need a locked unit as permanent placement due to alcoholism and behaviors. The guardian voiced no concerns other than making sure the resident would not be able to elope due to threats against the guardian. Review of the facility's investigation, dated 9/26/21, showed the following: -Date of incident 9/26/21; -At approximately 4:00 A.M., it was reported the resident was not in the facility and a code white (code used to alert staff that a resident was missing) had been called; -Multiple staff were sent out to search for the resident; -The resident's roommate (Resident #541), reported he/she was not aware the resident had left the facility. He/She reported seeing him/her at 8:30 (P.M.) smoke break and then he/she (Resident #541) arrived back into the room at 11:30 (P.M.). He/She noted a cool breeze in the room and reported to CNA D, then went to sleep; -Resident #157 reported that at 1:30 P.M. smoke break, the resident asked him/her to look up taxi companies. The resident told him/her that his/her family member was coming to town and he/she was needing a ride to the town where the facility was located. The resident did not tell him/her that he/she wanted the taxi numbers for him/herself. Between 4:30 and 5:00 P.M., he/she overheard the resident making reservations with the taxi company. He/She reported this information when he/she was aware the resident was gone; -CNA E worked the unit that night and was not scheduled on the 500 hall (secured hall where the resident resided), but he/she last saw the resident at 8:30 P.M. smoke break; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Licensed Practical Nurse (LPN) B said he/she saw the resident between 8:00 P.M. and 9:15 P.M. and noted the resident was within baseline. His/Her last face check was at 9:00 P.M.; -CNA C reported CNA E was performing face checks. CNA C was assigned to the 500 hall and he/she completed face checks every hour, but did not pull the resident's curtain back when he/she checked the resident's room; -The taxi company was contacted. After description of the resident, it was determined the resident was picked up at approximately 9:30 P.M. and was taken to a public park in a city (located approximately 40 miles from the facility); -Conclusion/summary: The resident eloped out of the bedroom window at an unknown time. No staff or residents heard sound of breaking glass, but the window was found to be shattered. The resident was picked up by a taxi company and driven to a city (located approximately 40 miles from the facility). Employees were immediately suspended and later terminated due to not properly completing face-to-face checks. Involved staff were able to verify they had received in-servicing/education on facility's procedure for completion of face checks. Review of Resident #541's written statement, provided by the facility, dated 9/27/21, showed he/she was not aware the resident left until that morning (9/27/21). He/She noted seeing Resident #501 when the resident woke him/her up for smoke break at 8:30 P.M. Resident #541 arrived back in his/her room around 11:30 P. M. and noted a cool breeze in the room. He/She did not notice the window was broken. He/She reported the cool breeze to CNA D and went to sleep. During an interview on 9/29/21 at 4:20 P.M., Resident #541 said he/she last saw Resident #501 during 8:30 P.M. smoke break, but did not notice him/her at the 10:00 P.M. smoke break. Resident #541's bed was close to the window, and he/she noted a breeze when he/she was assisted to bed. He/She told the CNA about being cool when CNA D assisted him/her to bed, but did not notice the window being broken at that time. Resident #501 often had his/her privacy curtain pulled. The window in the room was broken, but he/she must have been out of the room when the resident broke it. Review of CNA D's written statement, provided by the facility, dated 9/27/21, showed he/she worked from 7:00 P.M. until 11:00 P.M. on 9/26/21. He/She did not see the resident during that time frame. He/She assisted Resident #541 to bed at approximately 10:30 P.M. Resident #541 told him/her the resident was not in the room. CNA D asked if the resident had been gone all day, and Resident #541 said, no just this evening. CNA D pulled the curtain and noted the resident was not in the bed. Resident #541 said there was a cold breeze coming in the room. CNA D thought it was from the air conditioning unit because he/she saw the blinds moving. CNA D did not note any glass on the floor. CNA D covered up Resident #541 and left the room. CNA D did not report he/she conducted a face check between 8:30 and 9:00 P.M. or that he/she did not see the resident, because he/she had forgotten. He/She did not do walking rounds when CNA C arrived, but stood at the nurse's station and reported off to him/her. He/She did not tell CNA C that he/she had not seen the resident. Review of CNA C's written statement, provided by the facility, dated 9/27/21, showed CNA C came on shift at approximately 11:00 P.M. He/She received report from CNA D, but did not do walking rounds. He/She completed face checks every hour, but did not pull the resident's curtain, and did not physically see the resident while on shift. He/She noted the curtain and blinds were pulled down. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of CNA E's written statement, provided by the facility, dated 9/27/21, showed CNA E saw the resident at approximately 8:30 P.M. when he/she supervised the residents while smoking. CNA E was responsible for 400 face checks, and therefore did not complete face checks on the 500 hall (where the resident resided). During interview on 10/1/21 at 8:55 A.M., CNA E said he/she worked the 400 hall on 9/26/21 from 7:00 P.M. until 7:00 A.M. The resident attended the 8:30 P.M. smoke break then came back inside and went to his/her room. At approximately 3:00 A.M., a representative from an outside lab company came to draw the resident's blood. The laboratory representative came up to him/her and asked where the resident was because he/she was not in bed. They went to the resident's room and began to look for him/her, but could not locate him/her. LPN B said he/she saw the resident at 3:00 A.M., but CNA E did not see the nurse go room to room and check on each resident. The resident's roommate (Resident #541) was not aware the resident was gone, but did complain of his/her room being cooler. Review of LPN B's written statement, provided by the facility, dated 9/27/21, showed LPN B started his/her shift at 7:00 P.M. on 9/26/21. He/She was back and forth from the resident's unit to other units that evening. He/She last saw the resident between 8:00 P.M. and 9:15 P.M. His/Her last face check was at 9:00 P.M., but he/she returned to the unit every half hour to an hour and asked the CNAs if all residents were accounted for, if residents needed anything, and if staff needed anything. He/She trusted the CNAs to do face checks and let him/her know if anything was wrong. During interview on 9/29/21 at 11:30 A.M., LPN B said he/she was the charge nurse on 9/26/21 from 7:00 P.M. until 7:00 A.M. He/She saw the resident at approximately 9:00 P.M. walking to his/her room. He/She did not conduct face-to-face checks on the residents. He/She walked on the unit every half hour to an hour and asked the CNAs if there were any concerns. Staff never mentioned anything about a resident missing until 4:00 A.M. Apparently he/she was expected to go in every room every hour to lay eyes on the residents, but he/she did not recall being trained to do this. He/She trusted the CNAs to complete face checks, document everyone was there and accounted for, and to notify him/her if there were any concerns. At 4:00 A.M., he/she received a call from CNA C requesting he/she come to the unit. He/She was told staff were unable to locate the resident. After inspection of the resident's room, it was found the window had been broken. He/She was unaware Resident #541 complained of being cool in the room. During interview on 9/29/21 at 11:20 A.M., the taxi driver said he/she received a call on 9/26/21 at 7:30 P.M. to pick up the resident at 9:30 P.M. He/She picked up the resident from a gas station in the town where the facility was located on 9/26/21 at approximately 9:30 P.M. and drove him/her to a park in a city (located approximately 40 miles from the facility). The resident told him/her he/she was from Iowa. The resident had an odor of alcohol when he/she got into the taxi. The resident paid him/her $125.00 cash for the trip. He/She did not see anyone awaiting for the resident when they arrived at the destination city. During interview on 9/29/21 at 12:30 P.M., the resident's guardian said the resident had eloped or attempted to elope previously from three different facilities, and the current facility was aware of the resident's history. He/She was very upset because the facility told him/her they would keep him/her safe as the resident would be in a locked/secured unit. He/She was worried for the resident's well-being since he/she did not have any food, water, identification or money. (continued on next page)

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