STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A098	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD CARE CENTER VERMILLION	125 S WALKER STREET , VERMILLION, South Dakota, 57069

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F0000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 1/26/26 through 1/29/26. Areas surveyed included quality of care/treatment, potential resident abuse/neglect, misappropriation of property, and administration/personnel. Sanford Care Center Vermillion was found not in compliance with the following requirements: F600 and F689.	F0000		
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), interview, employee file review, and policy review, the provider failed to protect one of one sampled resident (3) from verbal abuse who had profanity verbalized toward her by certified nursing assistant (CNA) H. Findings include: 1. Review of the 1/12/2026 SD DOH FRI report revealed: *"A report was made on 1/12/26 involving [resident 4]	F0600	1.CNA H is no longer employed at the facility as of 1/28/26. CNA H was suspended on 1/12/26 pending investigation following the alleged event. Prior to returning to work on 1/15/26, CNA H completed required training on Customer Service, Disruptive Conduct & Behavior and Professional Communication in LTC. CNA H worked 5.5 shifts after returning to work prior to resignation/ termination on 1/28/26. Resident #3 was interviewed by Social Worker on 1/12/26, 1/29/26 and 2/12/26 and denied recollection of the event and reported satisfaction with care. Resident #4 was interviewed by the Social Worker on 1/12/26, 1/29/26 and 2/12/26 and reported no retaliation or fear and was satisfied with care. 2. All residents have the potential to be at risk and to determine if others were affected, interviews are being conducted by RN F or designee with 3 staff and 3 residents weekly to determine if anyone witnessed or experienced verbal, mental, physical or emotional abuse. DON/designee will ask residents at resident council meeting on 2/25/26 if they have witnessed or experienced verbal, mental, physical or emotional abuse. Findings will be addressed immediately by CEO/DON/ Designee. 3.DON/designee will conduct: •Mandatory Abuse Reporting Reinforcement o All staff re-educated beginning on 2/13/2026 regarding: ▪ CMS F600 requirements ▪ Definition of verbal abuse ▪ Mandatory reporting obligations ▪ Duty to report observed inappropriate behavior o Abuse Policy Re-education ▪ Abuse and Neglect policy distributed to all staff with required signature acknowledgment by 2/26/2026 ▪ Abuse storyboard education with post-test completed by all staff.	

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F0600 SS = D	Continued from page 1 who expressed concerns of verbal abuse by a staff member [CNA H] to another resident [resident 3]." *CNA H was interviewed by director of nursing (DON) A and clinical care leader (CCL) F on 1/12/26 and then sent home and remained on suspension pending the investigation. *Resident 3's date of admission to the facility was on 12/2/25. *Resident 3's most recent Brief Interview for Mental Status (BIMS) assessment score was 3 indicating severe cognitive impairment. *Resident 3 had pertinent diagnoses of dementia, hearing loss, chronic kidney disease stage 3. *Resident 4's date of her admission to the facility was on 2/1/24. *Resident 4's most recent BIMS assessment score was 15 indicating she is cognitively intact. *Resident 4 had pertinent diagnoses of left leg above knee amputation, depression, and post-traumatic stress disorder. *It was reported, "On the evening of 1/11/26 [Resident 4] heard [Resident 3] in the hallway saying "I need it now" repeating it a couple of times. [Resident 3] is known to be impatient and rude to staff. *[Resident 4] reports she overheard CNA H respond, "[Resident 3] shut the [expletive] up." *[Resident 4] stated she then wheeled herself to the hallway and confirmed it was CNA H who had said this to resident 3. *When resident 3 was interviewed the next day by social worker (SW) I, she did not remember the incident and reported she was feeling okay. *CNA H was given education on disruptive conduct and behaviors and online education for customer service. *CNA H was allowed to return to work after completion of education and disciplinary action. *Audits were to be conducted weekly by director of nursing (DON) A or designee for three months which include interviews with three staff CNA H had worked with that week and three residents that he has cared	F0600	▪Education incorporated into annual skills fair o RN F/designee will conduct Abuse Drills with staff at least twice per year o Leadership Oversight ▪ DON or designee will conduct weekly leadership rounding focused on respectful communication and dignity for 90 days ▪ DON/designee will conduct Charge nurse re-education immediate escalation expectations by 2/26/26 4. RN F/designee will conduct weekly audits for 1 month of 3 residents and 3 staff to inquire about any witnessed or experienced abuse. If no concerns are identified, audits will move to monthly for an additional 3 months or until substantial compliance as determined by the QAPI committee. Any positive responses will be reported to DON for immediate investigation and reporting to DOH. A review of the audits and results will be made by DON/ designee at the monthly QAPI meeting beginning on 2/18/26 for 4 months or longer as deemed necessary by QAPI committee.	2/26/26

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F0600 SS = D	Continued from page 2 for that week. *CNA K was interviewed on 1/13/26 at 3:00 p.m. by CCL F regarding the evening of 1/11/26 revealed: -When CNA K returned from her break at 5:00 p.m. CNA H was in a bad mood. She said CNA H seemed irritated and overwhelmed; she was unsure what had happened to put him in this mood. -She believed that was why he left early. -CNA H was being rude to her during that shift. -She had completed most of resident 3's cares that evening. -Resident 3 was no more demanding than usual that evening. -CNA K had seen CNA H get irritated before, but not swear at anyone. 2. Interview on 1/27/26 at 9:22 a.m. with resident 3 revealed: *She did not know the date or what day it was. *She said she was feeling fine. *When asked if staff had yelled at her she stated, "I don't think so." *When asked how staff treat her, she stated "okay." 3. Interview on 1/27/26 at 9:30 a.m. with resident 4 regarding the 1/11/26 incident revealed: *Resident 3 repeats things often and uses her call light often. *She had been sitting in her room on 1/11/26 across from resident 3's room. *She had overheard CNA H say to resident 3 to "Shut the [expletive] up" on 1/11/26 in the late afternoon. *She had pushed her wheelchair to the doorway and observed CNA H standing by resident 3 after she overheard the above statement. *She stated CNA H had always been nice to her.	F0600		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F0600 SS = D	Continued from page 3 *She has no fear of CNA H following the above incident. 4. Interview on 1/27/26 at 12:40 p.m. with minimum data set (MDS) Coordinator J revealed: *Customer service education had been assigned to all staff and she thought they had until the end of the month to complete the education. *Audits on CNA H had not started, she believed they would start this week. *CNA H had given his notice and is quitting on 2/1/26. 5. Interview on 1/27/26 at 3:15 p.m. with CNA H revealed: *He started working for the facility on 9/8/25. *He worked on the evening shift until 7:00 p.m. on 1/11/26 in the south hallway with resident 3. *He had toileted resident 3 and transferred her that shift. *Resident 3 required toileting assistance, transfer assistance, and wheeling assistance to meals in the dining room. *Resident 3 had behaviors of forgetfulness, verbally repeating things, demanding at times, combativeness with staff and would kick out at staff while they perform cares. *He said on 1/11/26 resident 3 wanted her requests completed immediately, was demanding and impatient. *He denied when asked, if he had told [resident 3] to "Shut the [expletive] up" on 1/11/26 while caring for her. *He had been suspended pending the investigation of the incident. *He thought he returned to work on 1/16/26 and had completed the facility required re-education before returning to work. *He has not worked with resident 3 or resident 4 since his return to work on 1/16/26.	F0600		

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F0600 SS = D	Continued from page 4 6. Interview on 1/28/26 at 11:40 a.m. with social worker (SW) I revealed: *She started working for the facility on 12/15/25. *She had interviewed resident 3 and resident 4 on 1/12/26 after the incident was reported to DON A by an unidentified CNA. *She had stated resident 3 did not remember anything that had happened the evening before. *Resident 4 stated to SW I that she had overheard resident 3 on her call light, as the buzzer sounds in the hallway and resident 3 was yelling "Help me right now, right now." *Resident 4 stated, she heard a male voice state to resident 3 to "shut the [expletive] up." *Resident 4 stated to her that she then wheeled herself to her doorway and observed CNA H standing outside her room. *She stated that resident 4 is a good source of information, she does not make up stories. *Resident 4 was even hesitant to tell her anything as she did not want to get anyone in trouble by talking with her. *Resident 4 has a BIMS assessment score of 15 out of 15 and is cognitively intact. *After completing the resident interviews, she forwarded the information onto DON A. 7. An interview with CNA K was requested by phone and email request, but she did not respond. 8. Interview on 1/28/26 at 2:11 p.m. with licensed practical nurse (LPN) E revealed: *She had worked with CNA H before. *She felt resident 4 was a reliable witness and truthful. *Resident 4 has reported observations before to her. *She had not yet completed the customer service	F0600		

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F0600 SS = D	Continued from page 5 education that had been assigned. *She had observed CNA H yell at a resident before that was exit seeking. *CNA H was still new and training and she used it as a teaching moment to tell him he could not talk to residents that way. This was on the night shift. *She had not notified anyone in management when that incident had occurred. 9. Interview on 1/28/26 4:47 p.m. with registered nurse (RN) L revealed: *She had worked on 1/11/26 with CNA H. He had left early around 6:30 p.m. *CNA H does not like to communicate with her. *CNA H had a sharp tone whenever he spoke to her that evening. *She had not had anything reported to her that evening regarding CNA H. *Resident 4 is a reliable witness, and if she told RN L something, she would believe it to be the truth. *She had completed the customer service training that had been assigned after the allegation was made. 10. Interview on 1/29/26 at 9:23 a.m. with DON A revealed: *She is unsure if resident 3 remembers the interaction. *Resident 3's cognition fluctuates, and she is hard of hearing. *She had completed some staff interviews for the investigation. *She considers resident 4 a reliable, trustworthy reporter for the most part; her cognition is intact. *She took what resident 4 had reported to be truthful. *CNA H was suspended pending the investigation; he missed 2-3 days of work. *CNA H received a written final warning.	F0600		

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F0600 SS = D	Continued from page 6 *CNA H was assigned and had completed staff education on professional communication in long term care and customer service before returning to work. *CNA H returned to work on 1/15/26. *No audits have been completed following the incident. *There had been no further follow-up with residents 3 or 4. *She expected staff to treat residents the way they wish to be treated, that this was their home, the staff were here to care for them. 11. Review of CNA H's employee file revealed: *He was hired on 9/8/25. *A background check had been completed on 8/19/25. *He completed Abuse, Neglect, and Exploitation education on 9/9/25. *He completed An Overview of Quality Dementia Care CNA education on 9/24/25. *There was a final warning written in file regarding the incident that occurred on 1/11/26. 12. Review of the provider's 4/11/25 revised Abuse and Neglect policy revealed: *"Patients and residents have the right to be free from verbal, sexual, physical, mental abuse, neglect, misappropriation of property, corporal punishment, exploitation and involuntary seclusion." *"Patients and residents must not be subjected to any kind of abuse by anyone, including, but not limited to, facility staff, other patients or residents, consultants, volunteer staff or other agencies serving the individual, family members, legal guardians or personal representatives, friends or other individuals." -"Verbal abuse refers to any use of oral, written, or gestured language that includes disparaging and derogatory terms to the resident or their families, or within their hearing distance, to describe patients/residents, regardless of their age, ability to	F0600		

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F0600 SS = D	Continued from page 7 comprehend or disability."	F0600		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, observation, and policy review, the provider failed to protect the safety of two of two sampled resident (1, and 2) identified as at risk for elopement (leaving the facility without staff knowledge) who had exited a secured door and crawled out of a room window and left the building without staff supervision. Findings include: 1. Review of the 11/22/25 SD DOH FRI report regarding resident 1 revealed: *Resident 1 was admitted to the facility on 4/14/25. *On the night of 11/2/25: -"Resident 1 was wandering around at his baseline looking for exits." -"At approximately 12:40 a.m. the south door alarm goes off." -"Resident 1 is in the south hall walking back toward the nurses station/central lobby." -"Nurse [registered nurse (RN) B] heads down to the far south door to turn off the alarm." -"Resident 1 turns to follow and immediately pushed open the south door and leaves the building at 12:42 a.m."	F0689		

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F0689 SS = G	Continued from page 8 "[RN B] Unable to see resident [1] in the parking lot." -"Due to [resident 1] history of aggression and it being dark outside, the nurse [RN B] contacted law enforcement for her [RN B] personal safety." -Camera's were viewed and resident 1 was in the car [police] at 12:48 a.m. being brought to the ambulance bay door." *"[Resident 1] was wearing jeans, a T-shirt and shoes." *"The temperature was 35 degrees outside." *[Resident 1] was found in our facility parking lot." *"On return to the care center [resident 1] is noted to be anxious with tense body posture and clenched fists." *[Resident 1] refused skin assessment and vitals." *Call with voicemail was left for family, and information was faxed to physician. 2. Review of resident 1's electronic medical record (EMR) revealed: * He had pertinent diagnoses of: -Unspecified dementia with agitation. -Depression. -Alcohol abuse, in remission. -Anxiety disorder. -Attention-deficit hyperactivity disorder, combined type. -Insomnia. *He had a roam alert (a wearable door alerting device) on his ankle starting on 4/29/25. *He had a Brief Interview for Mental Status (BIMS) score of 0, which indicated severe cognitive impairment on 9/12/25. *He was assessed on 9/11/25 and was identified as at risk for elopement.	F0689	1. Resident # 1 and # 2 no longer reside at the facility. a. Resident #1 i. 15-minute visual checks initiated immediately upon return from elopement on 11/2/2025 by RN B. ii. Roam Alert verified functional by RN J on 11/2/25. iii. Care plan updated by RN J to include increased supervision 11/2/25 iv. Resident #1 transferred to higher level of care on 12/16/25 due to high elopement risk and need for behavioral health care. 2. Resident #2 i. Resident assessed upon return from elopement on 1/20/2026; no injuries noted. ii. Window secured immediately by on-call maintenance; maintenance repaired frame on 1/21/2026 and again on 1/30/26. iii. Door to room locked to prevent access by other residents 1/29/26. iv. Resident discharged with family on 1/21/2026 2. All residents have potential to be affected. • All current residents reviewed for elopement risk by DON/designee by 2/26/26. • Roam Alert functionality verified for all residents with devices by RN J/designee by 2/26/26 • Environmental assessment completed on all resident rooms and neighborhood windows by DON and RN J by 2/18/26. 3. Maintenance staff put window locks on all resident room windows and the North, West and South neighborhood windows beginning on 2/9/26 with all windows completed by 2/18/26. The Elopement policy was revised on 2/13/26 to add that staff should initiate frequent visual checks on the resident when he/she returns from elopement. DON A put out elopement education on 2/13/26 for all staff to complete by 2/26/26 including the revised elopement policy and frequent check documentation sheet with cover letter and additional education on "Elopement Prevention and Resident Safety." The cover letter on the elopement policy addresses the following important points: : staff to do an overhead page to get staff from entire facility to assist in search for any missing/eloped resident; sending staff member(s) after resident if they are seen leaving to at least keep an eye on the resident at all times; ensuring staff that our parking lots are not dark at all and they are lit up with lights; staff should take a radio or cell phone with them when leaving the building; to call the DON if there is an elopement not text and to complete the Frequent Checks documentation sheet when doing the frequent visual checks on residents. This is in addition to our	

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F0689 SS = G	Continued from page 9 *He was administered Tylenol pm extra strength (a pain medication used for sleeplessness) on 11/1/25 at 8:45 p.m. for anxiety. *He was administered lorazepam (an anxiety medication) on 11/1/25 at 8:45 p.m. for anxiety, agitation, or behavioral disturbances. *He had been administered olanzapine (an antipsychotic medication) 5mg IM (intramuscularly) on 11/2/25 at 1:20 a.m. upon his return for behavior issues [elopement]. *He had been started on 15-minute visual checks on 11/10/25. *He was sent to the emergency department (ED) on 11/26/25 for suicidal ideation. *He was discharged from the ED and transferred to a higher level of care facility (HSC). *A telephone conference was held on 12/16/25 with HSC staff regarding discharge planning related to safety concerns. *Resident 1 was discharged from facility on 12/16/25 as facility could not meet the security needs. 3. Interview on 1/28/26 at 12:04 p.m. with certified nursing assistant (CNA) C revealed: *She had worked for the facility for four and a half years. *She worked the night shift from 11/1/25 at 10:00 p.m. to 6:30 a.m. on 11/2/25. *There is one nurse and three CNA's that typically work. *Resident 1 was having behaviors of agitation, exit seeking and threats against staff. *She was unsure if as needed (PRN) medications had been given to resident 1. *She was told by registered nurse (RN) B to stay in the building for resident and staff safety at the time of the elopement. *She had not completed any elopement drills since she started working for facility.	F0689	annual storyboard education on Emergency Procedures which covers the Elopement Policy that all nursing and aide staff complete. Elopement drills were held in April 2025 and December 2025. An elopement drill was held during the day shift at 1:30 PM on 2/13/26 and was passed; staff were reminded by RN F afterwards to check the resident sign-out sheet in case resident had signed out of the facility. Evening and night shift will also have drills done by 2/26/25. Future elopement drills are scheduled for April, June and December 2026. On 2/13/26 DON A also asked the vendor currently working on our new call light system if he could add a delay to the exit doors for residents wearing Roam alert bracelets. So, if residents have a Roam Alert bracelet on and press on the bar of the exit door to exit, it will lock the door with a delay for a few seconds such as 10-15 seconds before unlocking the door for them to exit the building. He is currently working on a quote to send the DON for this. 4. A check to ensure windows in resident room and neighborhoods are securely locked from the inside will be made on monthly Environmental Rounds by the team beginning on 2/17/26, by Environmental Staff when doing discharge cleaning of a resident room after resident discharges or passes away and Maintenance staff will add a PM to check outside window locks to ensure the screws are tight and secure twice per year. Any variances will be reported to DON A immediately to place a work order for immediate repair. Results of these checks will be reported to the Improvement Advisor who will report them at the monthly QAPI meeting beginning on 2/18/26 until the facility demonstrates sustained compliance as determined by the committee.	2/26/26

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F0689 SS = G	Continued from page 10 *She completed education since the incident on the new elopement policy. 4. Interview on 1/28/26 at 3:30 p.m. with RN B revealed: *She had worked at the facility for almost four years. *She worked the overnight shift from 6:00 p.m. on 111/1/25 to 6:00 a.m. on 11/2/25. *Staff communicated with each other using a walkie talkie system. *Resident 1 wore a roam alert device. *On 11/2/25 resident 1 was setting off door alarms. She was going to reset the alarm (to the south door) when he pushed through the south end door. When she looked towards door, he could not be seen outside. *She immediately called 911 and gave them a description of resident 1. *She did not feel safe sending staff out to search for resident 1. *Resident 1 required a lot of one to one due to his exit seeking, aggressive behaviors towards staff, and scaring other residents. She stated that he even pushed a staff member into oncoming traffic once when he exited the building and staff followed him. *She had administered PRN medication for anxiety earlier that evening, but it was ineffective. *She had tried distraction, food, and redirection that shift due to his wandering behaviors. *She has never been trained by the facility to deal with that type of behavior. *She had completed education since the incident occurred. The education focused on assessment, not on what to do if an actual elopement incident occurred. *Resident 1 started on 15-minute visual checks after the elopement occurred. *She has not participated in any elopement drill since she has worked at the facility.	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A098	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0689 SS = G	Continued from page 11 5. Review of the 1/21/26 SD DOH FRI report regarding resident 2 revealed: *Resident 2 admitted to facility on 1/13/26. *Resident 2's BIMS assessment score was 3, indicating severe impairment. *Resident 2 had a roam alert device placed on admission. *On 1/20/26 between 6:50 p.m. and 7:00 p.m. the charge nurse had been in resident 2's room to assist her. *"At approximately 7:50 p.m. a call was received from the police department, resident 2 was located by them five blocks from the facility." *"Resident 2 had removed the screen from her window and pried her window open enough to crawl out." *"As a safety measure the facility does not leave cranks on our residents' windows." *Resident 2 was returned to the facility at approximately 8:00 p.m. by police and a family member. *"The outside temperature was about 24 degrees." *Resident 2 "was dressed in sweatpants, a flannel shirt/jacket, with 2 T-shirts under that and sandals with socks. Family also reported, resident 2 had a blanket with her." *Resident 2 was fully assessed upon her return and vitals were taken and were within normal limits, she had no injuries. *Family wanted to take resident 2 home for the night. He received education from the facility that resident 2 was not safe to be left to stay at home alone and he signed an acknowledgement of safety reasons she should not be left home alone. He ensured someone would remain with her. *Family returned to facility on 1/21/26 at 8:52 a.m. to sign discharge paperwork. *They plan to find placement closer to where they live that has a secure memory care unit. *Hospice would continue to see resident 2 at her home to ensure continuity of care.	F0689		

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F0689 SS = G	Continued from page 12 *Family, physician, director of nursing (DON) and hospice were notified at time of elopement and at time of discharge. 6. Review of resident 2's EMR revealed: *She was admitted to the facility on 1/13/26. *She was in hospice care when she admitted to the facility. *She had pertinent diagnoses of: -Anxiety disorder. -History of falling. -Unspecified dementia (a group of symptoms affecting memory, thinking, and social abilities) with behavioral disturbances. -Diabetes (a condition involving disruptions in how the body regulates blood sugar). *Her BIMS assessment score was 3 on 1/15/26 indicating severe cognitive impairment. *Her elopement risk assessment dated 1/19/26 indicated she was "at risk" for elopement. *She had a doctor's order dated 1/15/26 for lorazepam (an antianxiety medication) 0.5 mg (milligram) tablet by mouth (PO) four times a day (QID). -She had taken all lorazepam doses on 1/20/26. *She had a doctor's order dated 1/13/26 for lorazepam 2 mg/mL (milliliter) to give 0.5 mg PO every two hours PRN. -She had not been given any PRN doses on 1/20/26. *She had a doctor's order dated 1/13/26 for lorazepam 2mg/mL to administer 0.5 mg by injection every four hours PRN. -She had not been given any PRN doses on 1/20/26. 7. Review of resident 2's baseline care plan completed on 1/13/26 revealed: -Roam alert was applied to her wrist on 1/13/26.	F0689		

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F0689 SS = G	Continued from page 13 -Roam alert was moved to her ankle on 1/14/26 as she had been trying to remove. -Behavioral concerns of elopement, confusion. -She was unable to recognize need for placement in nursing home due to dementia. -History of falls. 8. Interview on 1/27/26 at 1:05 p.m. with licensed practical nurse (LPN) D revealed: *She worked on 1/20/26 from 12:00 p.m. to 6:00 p.m. * LPN D and LPN E went to give resident 2's second tuberculin (TB) skin test that was due at 3:30 p.m. *Resident 2 was tearful, as her husband had recently passed away. *Approximately 45 minutes later, resident 2 was pacing the hallways then going back to her room. *She had noted that resident 2 had removed the inner screens to her windows. *She had notified clinical care leader (CCL) F of the removal of the screens. *CCL F told her to keep an eye on resident 2. *LPN D left the facility at the end of her shift at 6:00 p.m. that evening. *She had completed elopement education after resident 1 had left the building in November 2025. 9. Interview on 1/27/26 at 2:35 p.m. with CCL F revealed: *Staff were monitoring resident 2 on 1/20/26 as she was pacing and wandering the hallways. *Resident 2 had a roam alert device on. *There are no cranks on the window in her room, she was not aware of anything resident 2 could do other than remove the screens. *Resident 2 had an order for PRN anxiety medication;	F0689		

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F0689 SS = G	Continued from page 14 she was unsure if it had been given. *Floor staff can initiate 15-minute visual checks for closer monitoring, as they have done before for other residents. 10. Observation on 1/28/26 at 11:00 a.m. of resident 2's room revealed: *Door was shut. *Screens were in the windows. *There were no cranks on the windows for opening. *There was lock on the window. When released you could push the window open two to three inches until some resistance occurred. *The inner window frame has cracked wood in the lower right corner. *From the room floor to window ledge it is 28 inches. 11. Interview on 1/28/26 at 2:11 p.m. with LPN E revealed: *She started working at 2:00 p.m. on 1/20/26. *During shift report she was told by LPN D that resident 2 needed a second TB test. *Resident 2 was sad and tearful when she went into her room to assist LPN D with the TB test. *She was listening to music. *She would pack her things every day to leave. *She was verbalizing, wanting to leave and was visibly upset. *Resident 2 had been given two doses of lorazepam (an antianxiety medication) that day she thought. *She was aware that resident 2 was an elopement risk. *She wore a roam alert device. *At 4:00 p.m. on 1/20/26 she had observed resident 2 open her door and saw that her window screens were out of the frame, and resident 2 went to lie on her bed.	F0689		

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F0689 SS = G	Continued from page 15 *She had notified LPN D that the screens were removed. *CCL F had told staff after they noticed the screens were removed, that there were no cranks on the windows, and that resident 2 could not do anything. *She was notified by the police later that evening that resident 2 had left the building. *She notified the director of nursing (DON) A. *Resident 2 returned around 8:00 p.m. to the building, she was shivering and cold. *She sat her by the fireplace and gave her hot chocolate. *She completed vitals and skin assessment on resident 2 upon her return. *Resident 2 was wearing sandals and socks, a flannel shirt and two T-shirts. *DON A arrived shortly after resident 2 returned to the facility. *DON A talked with family, offered them support and arranged a therapeutic leave for overnight for resident 2. *Maintenance was notified to come and secure the window which he did. *She has not completed any elopement education following the incident. 12. Observation on 1/29/26 at 7:50 a.m. of resident 2's former room revealed that the doorknob was replaced and was completed by unidentified maintenance staff at the time of the observation. A lock was placed on the door, so no other residents have access to the room. The lock is on the door, and the room is secure as of 8:52 a.m. 13. Interview on 1/29/26 at 9:01 a.m. with DON A revealed: *She had arrived after resident 2 returned to the facility on 1/20/26, and resident 2 was sitting in the lobby with her suitcase and box packed. Resident 2 was wearing a flannel shirt and her family was with her.	F0689		

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F0689 SS = G	Continued from page 16 *She felt the staff should have been concerned when resident 2 removed her window screens. *A lock had been placed on resident 2's former room door to stop any further access by residents to the room and the window that was broken. *The facility had started 15-minute visual checks on resident 1 on 11/10/25 until he discharged to a higher level of care facility. *After resident 1's 11/2/25 elopement, only nurses were educated on the 10/22/25 elopement policy. *There has been no further education completed since resident 2's 1/20/26 elopement from the facility with any staff members. *She was unsure when the last elopement drill had been completed. *Elopement risk assessments were completed upon admission and quarterly depending on minimum data set (MDS) assessment. *Staff are notified of resident care needs through the Kardex (a quick reference guide for resident care) and shift change report, including if a resident has a roam alert device. *Staff were notified of an elopement over the walkie system by stating "security alert, missing resident room number." *She expected to be notified immediately when a resident has an elopement. *If a resident was an elopement risk, the first consideration for resident placement was in the memory care unit. *If there was no availability in the memory care unit, then the preference for resident placement was in the north hall, which had no outdoor access. This was where resident 1 and 2 resided. *Floor staff were allowed to initiate 15-minute visual checks for residents if wandering or exit seeking behaviors were noted. *She expected staff to utilize PRN medication if available and residents were showing signs of anxiety and pain.	F0689		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F0689 SS = G	Continued from page 17 14. Interview on 1/29/26 at 10:09 a.m. with Improvement Advisor G revealed the elopement policy was revised on 10/25/25 and the nurses had completed education and policy review following resident 1's elopement on 11/2/25. 15. Review of the provider's 10/22/25 Missing Person-Elopement policy revealed: **It is the facility's responsibility to protect patients/residents from harm. If a patient or resident should wander from the facility grounds/property without notice, the following procedure will be followed: -Elopement will be defined as any resident leaving the grounds of the facilities without knowledge of staff, or any patient/resident unable to be located on the grounds/facilities. -When a resident is discovered as missing or door alarm is activated, the DON/Charge Nurse will immediately be notified. At the Care Center, a beeper system hooked up to the call light system is activated and lights at the end of the hallway in question will flash red."	F0689		