STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435041	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN HEALTH AND REHAB	**1700 NORTH HIGHWAY 281 , ABERDEEN, South Dakota, 57401**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS An extended complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 2/24/26 through 2/26/26. Areas surveyed included potential resident abuse/neglect, quality of care/treatment, and quality of life. Aberdeen Health and Rehab was found not in compliance with an immediate jeopardy violation at F689.	F0000	The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law.	
F0689 SS = SQC-K	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 the South Dakota Department of Health (SD DOH) facility reported incident (FRI), observation, interview, document review, record review, and policy review, the facility failed to ensure the safety for one of one sampled resident (1) who was identified at risk for elopement (leaving the facility without staff knowledge) and left the building unsupervised on 2/13/26. Immediate Jeopardy (IJ) at F 689, severity K, began on 2/13/26 at 4:10 a.m. when the provider failed to ensure the safety of resident 1 who eloped through his bedroom window and was found at 4:38 a.m. outside when outdoor temperatures were approximately 25 degrees Fahrenheit (F), for an unknown amount of time, and the safety of any other residents identified at risk for elopement (total of 11). The facility failed to implement	F0689	F689, Free of Accident Hazards/Supervision/ Devices, Aberdeen Health & Rehab corrected the deficiency by verifying Resident 1's room was safely secured with a sliding window clamp lock and found unnecessary to apply a window alarm as of 2/24/2026. Locking mechanisms were placed on sliding widows in the following areas on 2/24/2026: tv room, restorative room on all three windows, one window in therapy room, two chapel windows, resident 2's room, resident 3's room, resident 4's room, resident 5's room, resident 6's room and resident's 7 room. MDSC was educated on 2/25/2026 completing care plans timely and as changes occur. MDSC completed elopement risk assessments for all current residents on 2/25/2026 and no new residents were identified as being an elopement risk. On 2/16/2026, ED reviewed the current Emergency Plan for Aberdeen Health & Rehab which included the elopement policy and procedure for the facility. The Emergency Operation Plan, including elopement policy was review by ED on 2/25/2026 and found no changes needed to be made. Storage room 125 was locked on 2/24/2026 and locking mechanisms were placed on sliding windows in storage room 125 on 3/12/2026. The activity door was secured with a door alarm that connects to the current call light system on 2/26/2026. The exit door by the laundry room and employee break room was verified to have an audible alarm and working correctly as of 2/26/2026. The assisted dining room emergency exit door was secured with a door alarm that connects to the current call light system on 2/26/2026.	03/17/2026

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 reverse for further 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
Kirstie Hoon, Executive Director	Executive Director	03/18/2026

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NAME OF PROVIDER OR SUPPLIER **ABERDEEN HEALTH AND REHAB**		STREET ADDRESS, CITY, STATE, ZIP CODE **1700 NORTH HIGHWAY 281 , ABERDEEN, South Dakota, 57401**	

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F0689 SS = SQC-K	Continued from page 1 appropriate safety measures to ensure all residents identified at risk for elopement could not exit the facility unsupervised and without staff knowledge. Executive director A was notified of the IJ on 2/24/26 at 6:03 p.m. and a removal plan was requested. The removal plan was received on 2/25/26 at 1:37 p.m., and it was accepted on 2/25/26 at 2:00 p.m. The IJ was removed on 2/25/26 at 3:25 p.m. as confirmed by onsite verification by the survey team. After the IJ removal, the severity of the non-compliance remained at an E. The current census was 73. Findings include: 1. Review of the provider's 2/13/26 SD DOH FRI revealed that certified nursing assistant (CNA) R and CNA S notified registered nurse (RN) J on 2/13/26 at 4:10 a.m. that resident 1 was not in his room, and his window was open with the screen pushed out of it. They checked the rooms on resident 1's wing and had the other facility staff members check the rest of the building. When resident 1 was not found, they searched outside, and CNA R found him lying in the grass at about 4:38 a.m. He did not have any major injuries, and his vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate) were normal. He was wearing a long-sleeved shirt, pants, socks, shoes, and two jackets. The temperature outside was around 25 degrees Fahrenheit (F). Staff secured his window, started 15-minute safety checks for 72-hours, changed his clothes, and helped him to bed. The facility management team, the resident's physician, and the resident's family were notified of the incident. The management team had a meeting that morning of 2/13/26 about resident 1's elopement and determined that his window did not have a safety stopper in place to prevent it from sliding open all the way. Maintenance staff placed a stopper and a window alarm	F0689	The West black door in the assisted dining room was secured with a sliding lock in the upper left corner on 2/26/2026. Resident 1's care plan was updated on 2/25/2026 and all like residents care plans were updated on 2/25/2026 that require sliding window clamp locks determined by elopement risk. 2. To correct the deficiency and to ensure the problem does not recur Executive Director, Director of Nursing and Maintenance Director were educated by COO on 2/24/2026 regarding the safety of all residents by ensuring that all interventions for a plan of correction on a final investigation report are implemented to prevent similar occurrences. Education also included the importance of element mitigation for all at risk residents. All staff were educated on the facility's elopement process, 2 hour rounding on each shift to ensure safety of residents, notification process of reportable events and location of elopement binders on each wing at the nurses station by 03/17/2026. Maintenance Director was educated by Executive Director on 3/13/2026 regarding safety of all resident by ensuring that all exit doors in the facility are locked or have an audible alarm. Education also included the importance of doors with key pad entry and the need to remain locked at all time for the safety of residents. Executive Director and/or designee will audit all sliding windows for locking mechanisms, all exit doors for locks or audible alarms and key pad entry doors to ensure they are locked 1 x per week for 12 weeks and then randomly to ensure continued compliance. Director of Nursing and/or Designee will audit care plans for those residents that are current elopement risks to ensure the care plans are updated with documentation of wander guard usage and/or safety mechanisms 1 x per week for 12 weeks and then randomly to ensure continue compliance. 3. As part of Aberdeen Health & Rehabs' ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process.	

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F0689 SS = SQC-K	Continued from page 2 on resident 1's window on 2/13/26 at 10:10 a.m. The management team interviewed the staff who were working at the time of the elopement and determined the last time resident 1 was seen was around midnight. At about 10:30 a.m., director of nursing (DON) B instructed maintenance staff to check every window in the building to ensure that they were unable to be opened far enough for someone to go through. Maintenance staff was placing stoppers on all of the sliding windows to prevent them from being opened more than a few inches. Minimum Data Set (MDS) coordinator/licensed practical nurse (LPN) H reviewed all resident care plans and pocket care plans (personalized plan that addresses a resident's care needs, goals, and interventions) to ensure they were up to date. The WanderGuards (a wearable door alarming device) were checked for placement and functionality for all residents who wore them and at risk for elopement. Executive director A ensured the elopement binders (a binder that contained a picture and description of the residents who were at risk for elopement) were current and that the elopement drills had been completed. DON B was completing all staff education regarding elopement, residents who were at risk for elopement, two-hour rounding (checking on residents' status and assistance needs) for all residents, and immediate notification of reportable incidents. The provider's five-day final investigation FRI report stated that resident 1 had not tried to elope since the 2/13/26 incident, and his physician started him on a medication for dementia (a group of symptoms affecting memory, thinking, and social abilities). Other interventions included checking that all the WanderGuard devices on the doors were functioning, and indicated that all of the other interventions were completed. 2. Observation on 2/24/26 at 8:52 a.m. of resident 1's window in his room revealed it had metal stoppers on the window so it could not be opened further than a few inches but there was no alarm on his window. 3. Observation on 2/24/26 at 9:15 a.m. of the sliding window in the tv room revealed that it did not have a metal stopper and it could be slid open far enough for a person to climb out of it.	F0689		

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F0689 SS = SQC-K	Continued from page 3 4. Observation on 2/24/26 at 9:28 a.m. of the sliding windows in the restorative room revealed there were three windows in that room. Two of them did not have the metal stoppers and were able to be opened far enough for a person to climb out of. The window that had the stoppers on it had a sign on it that stated “do not open windows”. There were two doors to access the restorative room from the resident hallway that did not lock. The restorative aide left the room unattended when bringing a resident back to their room. 5. Observation on 2/24/26 at 9:34 a.m. of the sliding windows in the therapy room revealed they had three windows that had the metal stoppers. One window did not have the metal stoppers and was able to be opened far enough for a person to climb out of. 6. Observation on 2/24/26 at 9:55 a.m. of the sliding windows in the chapel revealed there were two windows that did not have the metal stoppers and were able to be opened far enough for a person to climb out of. There were two doors to access the chapel from the hallway that did not lock. 7. Observation on 2/24/26 at 1:45 p.m. of the sliding window in resident 2’s room revealed that her window had a stopper on the left side of her window and did not have one on the right side. The right window was able to be opened far enough for a person to climb out of. 8. Observation on 2/24/26 at 1:47 p.m. of the surveyors' facility map that indicated resident rooms who were at risk for elopement revealed that there were four residents who were at risk for elopement whose rooms were located near the restorative room. 9. Interview and observation on 2/24/26 at 2:08 p.m. with CNA K in the nurses station revealed she had worked at the facility for about two and a half years. She was able to state the process for what to do if a resident eloped. There was an elopement binder at each nurse's station with resident’s identification information who were at risk for eloping. She knew that resident 1 had the metal stoppers on his room window because he eloped recently. She verified that resident 1 did not have an alarm on his window and was not aware that he was to have one.	F0689		

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F0689 SS = SQC-K	Continued from page 4 She was able to see the residents' Kardex (a report of the resident's care needs and interventions), but not their care plans. She carried a pocket care plan, which indicated the residents who wore WanderGuards, but it did not indicate that resident 1 was to have an alarm on his window. Resident 1's Kardex did not indicate that he needed to have an alarm on his window. CNA K reported that resident 1 had exit-seeking and wandering behaviors at times, that increased in the evenings. He would put on his jacket, grab some belongings, and stand by the exit door at the end of his hallway and at the therapy room exit door. He appeared anxious at times but was easily redirected to a different area. After his family left after a visit, he would get more upset. She documented his behaviors in the CNA charting on the computer, and she notified the nurse. CNA K reported that the door at the end of the hallway on both Arbor wings, resident 1's wing and the adjacent wing, had a magnet alarm that alarmed at the door alarm panel when the door was opened and needed to be reset by staff to turn it off. She recalled receiving mandatory education about elopements and two-hour rounding one to two weeks ago. 10. Observation on 2/24/26 at 2:36 p.m. of the restorative room revealed that there was no one in the room, the sliding windows did not have stoppers, and the doors to enter the room from the hallway were unlocked. 11. Interview on 2/24/26 at 3:40 p.m. with CNA P revealed they were still doing 15-minute safety checks for resident 1, but she could not find the documentation sheets. She asked another staff member and was told the office staff had taken those sheets. 12. Observation 2/24/25 at 3:55 p.m. of the sliding windows in resident 4 and resident 5's rooms revealed that they did not have stoppers on the windows, and they were able to be opened far enough for a person to climb out of. 13. Observation on 2/24/26 at 4:01 p.m. revealed that unoccupied room 125 was used for equipment and not for	F0689		

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F0689 SS = SQC-K	Continued from page 5 residents. There was a keypad lock on the door, but it was not locked. It was close to resident 1’s room, and the sliding window did not have metal stoppers on it. 14. Observation and interview on 2/24/26 at 4:04 p.m. of resident 3’s window revealed that it did not have metal stoppers, it did not close tight enough for it to be locked, and it opened far enough for a person to climb out of. Resident 3 stated she had an air conditioner in that window over the summer, which caused it to not lock properly. 15. Observation on 2/24/26 at 4:13 p.m. of resident 6 and resident 7’s sliding windows revealed they did not have the metal stoppers, and they had a magnet alarm on them. 16. Interview on 2/24/26 at 4:13 p.m. with CNA K revealed there were two stoppers in place on resident 1’s windows, but there was no window alarm. 17. Interview on 2/24/26 at 4:30 p.m. with CNA L and CNA M revealed that residents always had access to the television lounge, restorative therapy room, and the chapel. 18. Interview on 2/24/26 at 4:36 p.m. with business office assistant (BOA) N revealed that the interior double doors to the therapy room were always open. No one could enter the therapy room through the outside door after 5:00 p.m., and the residents had access to that room at any time of day. 19. Observation and interview on 2/24/26 at 4:43 p.m. with executive director A and maintenance director G in resident 1’s room revealed that there was no alarm on resident 1’s window. There were metal stoppers placed on the window. Executive director A stated she picked up a window alarm at a local store on 2/13/26. Maintenance director G tried to place it on resident 1’s window, but it did not fit correctly. Another one needed to be ordered online. It had not yet been ordered. The metal window stoppers were purchased on 2/13/26, they arrived on 2/19/26, and maintenance director G had been installing them in the residents' rooms when “he	F0689		

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F0689 SS = SQC-K	Continued from page 6 had a chance”. Maintenance director G did not tell executive director A that the window alarm did not fit resident 1’s window. Executive director A was aware that resident 1’s care plan indicated he had the alarm on his window, and it was reported to the SD DOH as being completed. Executive director A was not aware that not all of the resident-occupied rooms had the metal stoppers on them, which included a resident who was identified as at risk for elopement. She stated, “he [maintenance director G] will do that today.” They did not have a date set for placing the metal stoppers on non-resident care rooms, and executive director A stated, "they all [windows] need to be done [have stoppers installed]”. 20. On 2/24/26 at 6:03 p.m. executive director A was notified of IJ at F689, regarding a resident who eloped through his bedroom window and failing to implement appropriate safety measures to ensure all residents identified at risk for elopement could not exit the facility unsupervised and without staff knowledge. A removal plan was requested. On 2/25/26 at 1:37 p.m. the removal plan was received. The removal plan was reviewed and accepted on 2/25/26 at 2:00 p.m. REMOVAL PLAN: “On 2/24/2026, Administrator, Director of Nursing and maintenance director were educated on the process of submitting a final report and the action plan in a final investigation report. They were also educated on the importance of elopement mitigation and ensuring the safety of all residents at risk for elopement. All windows were locked. On 2/24/2026 at 5:38 pm, Maintenance Director placed sliding window clamp locks on sliding windows including resident 2’s room, the tv room window on TCU dining, the activity/restorative room, the therapy room and the chapel. Resident 1’s room was safety secured with a sliding window clamp lock and found unnecessary to apply a window alarm at this time. Audit: All sliding windows in the facility were audited by Administrator and Director of Nursing at 6:38pm on	F0689		

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F0689 SS = SQC-K	Continued from page 7 2/24/2026 and all sliding windows in the facility were found to have safety mechanisms consisting of sliding window clamps locks. All door alarms were checked and verified by [name redacted] Administrator at 7:30 pm on 2/24/2026 that they were in working order. Maintenance assistant [name redacted] completed the weekly door check on all doors on 2/23/2026 resulting in all doors passing alarm testing. On 2/25/2026, [name redacted], MDSC was educated on completing care plan and pocket care plans timely and/or updated as changes occur. Resident 1's care plan was updated on 2/25/2026 and all like residents care plans were updated on 2/25/2026 that require sliding window clamp locks determined by elopement risk. As per final state report all staff were educated 2/13/2026-2/18/2026 on the following topics: Elopement Process/Policy, 2 hour rounding, notification expectations of reportable events to the Administrator, Director of Nursing, Physician, and family members, and who our current wander guard residents are and how we identify them. On 2/25/2026, [name redacted], Director of Nursing contacted staff that received the mandatory education information in their work mailbox have received the training information. On 2/25/2026, [name redacted], MDSC completed elopement risk assessments for all current residents in the building. No new residents were identified as being an elopement risk. On 2/16/2026, [name redacted], Administrator reviewed the current Emergency Plan for [provider]. This review included the Elopement policy and procedure for the facility. The Emergency Operation Plan, including elopement policy was reviewed by [name redacted], Administrator on 2/25/2026 and found no changes needed to be made. Any concerns will be reported to the administrator immediately and addressed in the facility QA [quality assurance committee]." 21. Observation and interview on 2/25/26 at 2:04 p.m. with executive director A and maintenance director G while observing the facility's windows that were not previously secured, revealed that resident 5's window	F0689		

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F0689 SS = SQC-K	Continued from page 8 did not have the metal stoppers on it. They stated they did not think they needed to be on it because it slid upward and not sideways, and they verified it opened far enough for someone to climb out of. 22. Interview on 2/25/26 at 2:40 p.m. with BOA N revealed that she received education after resident 1’s elopement on 2/13/26. It included the elopement policy, who needs to be notified when there is an elopement, and submitting the information to the DOH. 23. Interview on 2/25/26 at 2:42 p.m. with RN O revealed he received education after resident 1’s elopement. It included the elopement policy, who needed to be notified of the elopement and when, and included follow-up interventions when an elopement occurs. 24. Observation on 2/25/26 at 2:45 p.m. with executive director A and maintenance director G of the facility’s windows that were not previously secured, revealed that they all had the metal stoppers and were now secured. 25. Interview on 2/25/26 at 2:48 p.m. with CNA P revealed she received education on 2/13/26 after resident 1’s elopement. It included a review of the elopement policy, rounding every two hours on all residents, and information on interventions if an elopement occurs. 26. Interview on 2/25/26 at 3:00 p.m. with DON B revealed that the staff who had not yet completed the elopement education would complete it prior to their next shift worked. 27. Record review revealed that ten random residents who were not previously identified as at risk for elopement had elopement risk assessments completed on 2/25/26. The eleven residents that were previously identified as being at risk for elopement had current elopement risk assessments completed, their care plans were up to date, their pocket care plans were up to date, their WanderGuards were documented as being checked for placement and functionality, and elopement drills were completed. The survey team verified onsite, through observations, interviews, and record reviews, that the provider	F0689		

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F0689 SS = SQC-K	Continued from page 9 followed their IJ removal plan and the immediacy was removed. The scope and severity level of the noncompliance remained at an E. 28. On 2/25/26 at 3:25 p.m. executive director A was notified that the IJ had been removed. 29. Observation and interview on 2/26/26 at 9:03 a.m. with maintenance director G checking the door alarms throughout the facility revealed the door in the activity room had a magnet alarm that alarmed when it was opened, but the alarm turned off immediately after it was closed. It did not need to be reset by staff to turn the alarm off. The exit door by the laundry room and employee break room had a red alarm box with a keyhole on it, which did not alarm when it was opened. The door alarm was not activated, and he had not checked this door since he started working at the facility. Maintenance director G activated it, and it was functioning. He was unaware if anyone else had keys to turn that alarm off. There were two black doors in the dining room that opened to the courtyard that were unlocked and not alarmed. They were unable to be opened more than a few inches at this time due to snow that was packed behind them. He did not check these doors because he thought they were always locked. He started working at the facility at the end of January, and the previous maintenance director resigned before that. Executive director A and regional maintenance director Q completed his orientation. He went over the easement doors exit doors with regional maintenance director Q during his orientation, but not all of the exit doors. 30. Interview on 2/26/26 at 9:21 a.m. with activities director I revealed that the two doors that accessed the activity room from the hallway were always kept unlocked. She was not aware if the exit door in that room could be locked. 31. Interview on 2/26/26 at 9:55 a.m. with executive director A revealed she had problems with her previous maintenance director completing his duties. He was no	F0689		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN HEALTH AND REHAB	1700 NORTH HIGHWAY 281 , ABERDEEN, South Dakota, 57401

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F0689 SS = SQC-K	Continued from page 10 longer working there when maintenance director G's employment there started. She and regional maintenance director Q completed maintenance director G's orientation, and he planned for him to have more education completed after three months of employment. She expected that all exit doors would be secured and checked routinely. She acknowledged that the immediate jeopardy (IJ) removal plan indicated she verified that all exit door alarms were in working order on 2/24/26 at 7:30 p.m. She stated that she must have missed checking the activity room door, the exit door by the laundry room, and the two black doors in the dining room. 32. Interview, observation, and document review on 2/26/26 at 11:30 a.m. with executive director A and maintenance director G revealed that the once unsecured doors were now secured, and they were now added to the weekly door check audit. 33. Interview on 2/26/26 at 8:17 a.m. with DON B revealed that CNAs did not complete behavior documentation on resident 1 because the nurses were completing it. She was unaware that resident 1 had any exit-seeking behaviors. She was aware that he was sometimes up during the night. His doctor started him on medication for dementia symptoms last week. 34. Interview on 2/26/26 at 8:36 a.m. with RN J revealed resident 1 was usually awake around midnight to 3:00 a.m., he usually wanted his room door closed, and he would sometimes go sit in the dining room for a snack. He explained resident 1's elopement incident with no discrepancies to the information included in the FRI report. He stated he did not witness resident 1 attempt to go outside or open his window before that incident occurred. 35. Interview on 2/26/26 at 9:00 a.m. with CNA R revealed that when she began to work on 2/12/26 at 10:00 p.m. resident 1's door was closed, and it was usually left open a crack. She did not open his door because she did not want to wake him up, because then he would be more confused and wander. She last saw him around midnight. When she entered his room to empty his catheter at 4:10 a.m., he was not in his room. She notified RN J. Herself, RN J, and another CNA saw that his window was open, so they climbed out of his window to look for him. They could not find him immediately, so they went back inside to search for him. They could	F0689		

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F0689 SS = SQC-K	Continued from page 11 not find him inside, so they went back outside with flashlights and found him lying on the ground behind the garbage dumpsters at the back of the building in the brush. She never saw him try to get out of his window or the doors before that incident. She stated that when he wandered, he was easily redirected. 36. Interview on 2/26/26 at 12:25 p.m. with executive director A revealed she expected all the facility doors and windows to be secured. She expected the maintenance department to have monitored all of the exit doors. She was responsible for making sure the maintenance director completed his duties. 37. Review of maintenance director G’s training record revealed he received training regarding how to complete and document monthly door inspections on 1/27/26 and 1/28/26 by regional maintenance director Q. 38. Review of the providers 2/24/24 Director of Maintenance Job Description revealed “the primary purpose of your job position is to plan, organize, develop, and direct the overall operation of the Maintenance Department in accordance with current federal, state and local standard, guidelines, and regulations governing the facility, and as may be directed by the Executive Director, to assure that the facility is maintained in a safe and comfortable manner.” 39. Review of resident 1’s medical record revealed he was admitted to the facility on 1/20/26. He had diagnoses of dementia without behavioral disturbances and anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability). His 1/23/26 brief interview for mental status (BIMS) assessment score was 3, which indicated he had severe cognitive impairment. His 2/4/26 care plan indicated he used a walker to ambulate, he had impaired thought processes and decision-making abilities, and the staff was to report to his physician any changes in cognitive function. His elopement risk assessment score on 1/20/26 was 5, and on 2/13/26 was 6, which both indicated that he was at risk for eloping. He was identified as a wander risk	F0689		

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F0689 SS = SQC-K	Continued from page 12 and the staff were to check his wander guard for proper placement, observe his behavior and attempt to determine a pattern, frequency, intensity, and triggers. It indicated a window alarm was placed on his window on 2/13/26. He had a 1/20/26 admission note written by RN F that indicated he had a history of wandering and elopement. On 1/21/26 he received physician orders for the use of a WanderGuard. His skilled nursing notes from 1/23/26 through 2/13/26 at 3:11 a.m. indicated he was confused and did not exhibit behaviors. On 2/13/26 at 9:39 a.m., his skilled nursing note, written by assistant DON (ADON),LPN D, indicated he was confused and had mood and behavior changes, but it did not state what those changes were. On 2/13/26 at 1:13 p.m. a nursing progress note written by ADON, LPN D indicated a fax was received from resident 1's physician to monitor his scratches and abrasions he received when he eloped for signs of infection. His skilled nursing notes from 2/14/26 at 4:12 a.m. through 2/24/26 at 9:00 a.m. indicated he was confused and did not have mood or behavior changes. A 2/15/26 at 5:27 a.m. adverse event follow-up note written by RN J stated he continued on 15-minute checks, he slept until 10:30 p.m., was awake and up in his room until 12:30 a.m., and he went out in the hallway once. A 2/16/26 at 5:30 a.m. adverse event follow-up note by RN J indicated he continued on 15-minute checks, was up at 12:30 a.m. for a sandwich, and fell back to sleep at 2:00 a.m. A 2/17/26 at 1:45 p.m. progress note by RN O indicated that physician orders were received for dementia medication. On 2/22/26 at 12:34 a.m. a behavior note by LPN N indicated that he was up at 12:10 a.m. for a snack, and he was watching the therapy room exit doors. On 2/22/26 at 12:51 a.m. a behavior note by LPN N stated he had his coat on and collected some of his belongings and was watching the therapy doors, but was able to be redirected back to bed. 40. Review of the providers 10/29/24 Missing Resident/Elopement Process policy revealed that an	F0689		

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F0689 SS = SQC-K	Continued from page 13 elopement risk assessment would be done on admission, readmission, quarterly, annually, and with any significant change. The care plan would be updated as needed based on the risk assessment. Missing resident identification forms would be completed on admission and annually for resident's who were identified as moderate or high risk for elopement. If a resident was identified as moderate or high risk for elopement they could wear a wander guard, they would keep a current photo of the resident, staff were to respond to exit alarms immediately, staff were to encourage resident activities to distract them, and the resident's care plan would address behaviors to include resident specific goals. When a resident was missing staff would notify the charge nurse, and all staff would search the facility. If not located, staff would then search the grounds. If not found then the executive director, DON, family or legal representative, attending physician, and police would be notified. When the resident was located they would have a head to toe assessment completed to identify injuries, and the physician would be notified of the assessment results. The resident's family would be notified of the resident's condition and the residents condition would be monitored every shift for 72 hours. An incident and investigation report would be completed. The incident report would be reviewed at the monthly safety committee and quality assurance meeting. All staff would be educated during orientation and annually on the proper identification, assessment, and treatment of residents who were identified as at risk for exit seeking. Missing resident drills will be completed on all shift every month.	F0689		