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E 020 SS=L	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.73(b)(3) §403.748(b)(3), §416.54(b)(2), §418.113(b)(6)(ii), §441.184(b)(3), §460.84(b)(3), §482.15(b)(3), §483.73(b)(3), §483.475(b)(3), §485.68(b)(1), §485.542(b)(3), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b)(1), §494.62(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCIs at §403.748(b)(3) and ASCs at §416.54(b)(2) and REHs at §485.542(b)(3):] Safe evacuation from the [RNHCI or ASC or REHs] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance.	E 020		

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

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.

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E 020	Continued From page 1 * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop and implement emergency preparedness policies and procedures for the safe evacuation of residents from the facility. The facility failed to coordinate an orderly and safe evacuation of residents. Residents moved in the middle of the night without their medical records, medications, personal possessions and without their family, guardians, and next of kin being informed. The facility did not have effective means of communication when the facility phone lines did not work. Facility records of where residents relocated to were incomplete. The facility failed to take measures to ensure security of the residents and staff during the evacuation, and failed to secure resident belongings from theft. The failures jeopardized the health and safety for all residents and staff. The census was 174. Review of the emergency procedures showed	E 020		

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they were updated and signed by the Administrator on 11/15/23.
-Purpose: to set forth basic responsibilities and outline actions to be taken to protect life, provide resident care and protect property in this nursing home during man-made and natural disaster situations;
-Situation- A local disaster, such as fire, high winds, tornado, explosion, earthquakes, utility outage, terrorism, floods, etc may occur at any time and affect this nursing home;
-Responsibility for Coordinating Emergency Actions (Administrator):
-2. Assumes control of enacting emergency actions within the nursing home;
-3. Assigns tasks to emergency staff;
-4. Augments departmental staff with any available personnel;
-5. Directs recall of off duty personnel;
-7. Order evacuation of the nursing home if necessary.
-Staff walkout was not identified or addressed in the emergency procedures.

1. Record review of an email dated 12/15/23 at 2:27 PM, showed the ownership's Chief Financial Officer (CFO) told the Administrator: "After a long fight to get the ownership to fund Northview's continuing losses, I, nor (Owner A) have been able to get funds from the other part of the ownership group for Northview. (Owner A) is not able to fund this as he has exhausted everything he has from funding his homes for so long. I am not sure what to say as I have had many solutions to get us through our cash flow issues, but I do not have a solution this week. I spoke to (Owner A) and he suggested that you give employees (Owner B's) office information as we were expecting funds from him and he is not

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budging."

During an interview on 12/15/23 at 3:45 P.M., the Administrator said Owner A refused to pay staff, and said he did not have the money. The CFO told the Administrator to contact Owner B to get the money for payroll. The administrator stated it was payday, and people were walking off shift. CFO told the Administrator to transfer as many residents as possible to Facility B and Facility C (under ownership of Owner A). At 4:50 P.M., the Administrator said their emergency preparedness plan had been enacted.

Review of an email dated 12/15/23 at 5:14 P.M., showed Department of Health & Senior Services (DHSS) administration emailed CFO, Owner B's chief financial officer, and the registered agent for Northview Village, Inc, requesting immediate contact due to payroll not being funded, putting over 170 residents at immediate risk, and the facility's intent to implement their emergency preparedness plan and evacuate the building. No response was received on 12/15/23.

Observation on 12/15/23 at 6:00 P.M., showed multiple cars and vans on both sides of the street, adjacent to the facility's front entrance, making entry difficult. Staff were outside and inside the front lobby, including a security guard.

During an interview on 12/15/23 at 6:15 P.M., Licensed Practical Nurse (LPN) C said when employees found out they would not be paid, staff came in for work and turned around and left.

During an interview on 12/15/23 at 6:20 P.M., Certified Medication Technician (CMT) D said she talked with the Administrator about 3:10 P.M. and

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she showed CMT D the letter on her computer, saying staff would not be paid.

During an interview on 12/15/23 at 6:30 P.M., two visitors said the phones were shut down. They tried to call the facility about their family member, but could not get through because the phones were down.

During an interview on 12/15/23 at 6:35 P.M., the Administrator said the phone lines were not down. The Administrator from Facility B was getting vehicles to move beds from this facility to Facility B. Someone from Facility B was calling families. The Administrator said there were staff on all floors, including agency staff, taking care of the residents. Agency staff had been paid, so she knew they were staying in the building. She said staff were looting and someone stole gas from the facility van. All residents were still in the facility. The Administrator said she had been threatened. Residents would be going to Facilities B, C, E and F.

Observation and interview on 12/15/23 at approximately 7:00 P.M., showed transportation staff from Facility G entered the administrator's office and offered to assist with placement of residents. The administrator told him/her that nobody was going to Facility G. The transportation staff then left the office. The Administrator said some residents would be transferred tonight, but some will not go until tomorrow.

Observation of the fifth floor on 12/15/23 at 7:07 P.M., showed one agency LPN (LPN F), one CMT and one agency Certified Nurse Aide (CNA G) on duty. There was a lot of activity on the

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floor, with representatives from other facilities reading medical records, bagging medications from the medication carts, obtaining medical records and resident belongings. During an interview, the agency LPN said there was no security tonight, so his/her agency told her to leave for his/her own safety. He/She would be leaving in a few minutes. CNA G said he/she was on duty until 7:00 A.M.

During an interview on 12/15/23 at 7:18 P.M., Resident #11 said nobody had said anything to him/her about moving and he/she did not want to move.

Observation of the fourth floor on 12/15/23 at 7:34 P.M., showed three CNAs, one CMT and the Assistant Director of Nurses (ADON). There was a lot of activity on the floor, with representatives from other facilities reading medical records, bagging medications from the medication carts, obtaining medical records and resident belongings. During an interview, the ADON said there were 47 residents on the floor. Five residents left and a bunch more were leaving. The elevator near the nurses station became stuck, with people trapped on it.

During an interview on 12/15/23 at approximately 7:38 P.M. Resident #12 said he/she did not know if he/she was leaving the facility or not. He/she was worried about getting his/her money from the resident trust account. The resident was tearful during the interview.

During an interview on 12/15/23 at approximately 7:40 P.M., the Administrator from Facility H said he/she had 15 skilled nursing facility beds available, but was told by the Administrator that

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all residents had been placed at this time.

During an interview on 12/15/23 at 7:49 P.M., Resident #13 said he/she did not know where he/she was going and may not be transferred to another facility until 12/18/23. That is what he was told by staff.

During an interview on 12/15/23 at 8:00 P.M., the Administrator said she was unaware the elevator was stuck and that she and the Director of Nursing (DON) would be in the facility the following day.

During an interview on 12/15/23 at 8:25 P.M., a fireman said the elevator had too many people in it and that was why it was stuck. There had been nine people on it. At that time, a family member said they were on the stuck elevator for 30 minutes, and that included his/her family member, who was in a wheelchair. At that time, two utility workers entered the facility, for a report of a potential gas leak/gas odor in the kitchen.

Observation on 12/15/23 at 8:25 P.M., showed no security on duty at the front desk.

During an interview on 12/15/23, at approximately 10:00 P.M., the Admission Coordinator from Facility I said she was trying to help place residents at his/her skilled nursing facility, but it was "chaos" and resident charts were missing.

During an interview on 12/15/23 at 10:20 P.M., a representative of Facility D said Resident #2's medical record was taken by another facility, but the resident did not want to go to that facility. During an interview, Resident #2 said he/she was admitted at 4:00 P.M. that same day, and he/she

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was his/her own responsible party. He/She wanted to go to Facility D, and not to the facility who took his/her records.

During an interview on 12/15/23 at approximately 11:15 P.M., the Corporate Accounts Payable Staff Person J said 37 residents were going to be sent to local hospitals via Emergency Medical Services (EMS).

Observation on 12/15/23 at 11:15 P.M., showed three residents remained on the fifth floor. Two people identified themselves as volunteers on the floor. At that time, a representative from a home health agency, who had previously been on other units, walked freely on the floor. At 11:18 P.M., an alarm continued to sound. The two volunteers said they were not previously known volunteers of the facility and showed up to help.

During an interview on 12/15/23 at 11:30 P.M., the Administrator said she did not know of any volunteers on any of the units, nor was she aware of the home health agency representative on the floor. She and the Marketing Director went to the fifth floor at that time, and she said she would "take care of" him/her. At 11:42 P.M., the Administrator said to her knowledge, there were 34 residents still in the building and they were all going to Facility B and Facility C. At 11:48 P.M., the Administrator said the Internet and phone worked. The Marketing Director informed her the phones did not work and there was no security on duty. The Administrator verified the phone lines did not work.

Observation on 12/16/23 at 12:05 A.M., showed members of the fire department in the main lobby area of the building. During an interview at that

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time, one of the fire fighters said they were going to start on the 5th floor and work their way down, evacuating residents.

During an interview on 12/16/23 at 12:45 A.M., the St. Louis EMS Chief said his goal was to evacuate the building.

During an interview on 12/16/23 at 12:50 A.M., Resident #14 said he/she wanted to go to Facility J.

During an interview on 12/16/23 at approximately 12:55 A.M., an EMS staff person said they were taking Resident #14 to Facility K, not Facility J. He/She added that it was very sad that these residents were leaving all of their belongings behind; their whole world.

Observation on 12/16/23 at 12:50 A.M., showed EMS assisting Resident #3 to a stretcher. No staff were on the fifth-floor unit, where he/she resided.

During an interview on 12/16/23 at 12:55 A.M., Resident #4 said he/she was really wet and had been for over an hour. He/She said he/she was really angry. At that time, the ADON was informed the resident requested assistance and was quite upset. The ADON responded, "when isn't (he/she)?" EMS entered the room a few minutes later, talking with the resident who continued to be upset. Two other residents were in bed, and a third resident ambulated in the hallway with a representative from another facility.

Observation on 12/16/23 at 1:22 A.M., showed 8 residents on the third floor. One nurse was on the floor. Two residents and Nurse I remained on

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the second floor. The last resident on second floor (Resident #5) refused to leave, and several EMS had to physically lift the resident to a stretcher, while he/she protested.

During an interview on 12/16/23 at 1:25 A.M., Resident #15 said he/she was told he/she would be going to Facility L. He/She did not want to go there.

During an interview on 12/16/23 at approximately 1:27 A.M., Resident #16 said nobody had told him/her that he/she was going to be moving.

During an interview on 12/16/23 at 1:28 A.M., Resident #17 said nobody had told him/her that he/she was going to be moving.

During an interview on 12/16/23 at 2:30 A.M., the Administrator from Facility M said she had Resident #18's medical chart and medications, but another unknown facility took the resident to their facility. She said it was "a free for all up there."

Observation on 12/16/23 at 4:10 A.M., showed Resident #7 was the only person on the third floor. He/She lay in his/her bed. Observation at 4:12 A.M., showed an unknown female staff person exited the elevator onto the floor. He/She said everyone was off of the floor at that time. When told Resident #7 was in his/her room, the staff person said he/she did not realize anyone was left on the floor.

Observation on 12/16/23 at midnight through 5:30 A.M., showed multiple residents in the lobby. Several facilities were loading personal items in their vehicles, EMS transported residents on

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stretchers, and the City Police were onsite and secured the front desk. At 4:00 A.M., Resident #6 refused to leave, Resident #7 repeated concerns that his/her parents would not know where he/she was, and Resident #8 loudly refused to go. EMS administered two Haldol (antipsychotic) injections prior to several EMS lifting him/her to a stretcher. At 5:30 A.M., Resident #8 was the last resident to leave the facility.

Review of Resident #8's face sheet, showed his/her diagnoses included cognitive communication deficit (an impairment in organization/ thought organization, sequencing, attention, memory, planning, problem-solving and safety awareness), anxiety disorder, schizoaffective disorder (a chronic mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions, and symptoms of a mood disorder, such as mania and depression), persistent mood disorder and intellectual disabilities.

Observation on 12/15/23 from 6:00 P.M. until 12/16/23 at 6:00 A.M., showed the DON left the facility and did not return to any of the resident floors. The Administrator was not observed assuming control of enacting emergency actions within the nursing home, assigning tasks to emergency staff, or augmenting departmental staff with any available personnel. The Administrator stayed in her office and did not participate in the final floor sweeps conducted by the Fire Department.

During an interview on 12/21/23 at 10:56 A.M., the DON said on Friday, 12/15/23, she started receiving calls at 5:30 AM about the paychecks

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and staff saying the money was not there. She tried to get staff to calm down. The DON went into work. The DON talked to the Administrator who said she got an email from the CFO the previous day telling her to call the other two owners about making payroll. The Administrator refused to call or email the other owners and told him he needed to tell her what to tell people about their pay. The staff were ok on day shift and everyone worked normally and did their jobs. No one was "wigging out". The DON was on the 4th floor at 3:00 P.M. when CMT D talked to the DON. They went down to the Administrator's office. CMT D asked the Administrator about it and the Administrator had an email that was sent to her and the Corporate Nurse. They had exhausted all avenues and there were no paychecks. The CFO was blaming the other two owners and the other two owners wouldn't pay. They gave them nothing to tell the staff. The Administrator gave out the phone numbers of the owner, they printed it and handed it out. When staff called the numbers, they were hanging up on them. The DON also called Owner A and left a message. Everything "went left". Dayshift was outside. Some were also in the lobby. Some staff were quiet and others were not. The DON doesn't know who called the evacuation. Once she saw evening shift was there, she was ok with that. She went out front and she called the police twice herself. She also tried to call the floors and couldn't get through. The phone lines were cut. She did not know who cut them. The DON knows she looked up and saw the Administrator and DON from Facility B there, and three staff from Facility C, and that someone had called the evacuation. She saw the Administrator and DON from Facility E there, then DHSS staff. She was unsure how to organize this. She left sick at

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10:00 P.M. after she threw up. She knew it was her nerves. She saw other homes were there, and nurses sent by the Medical Director and Physician L. There was a nurse on each floor. As homes came to see people, she told them they could look through the charts and then call their family members. They had notepads and the nurses were supposed to keep track of who was going where, but it was overwhelming. The facilities were pulling charts and not signing in. They were going floor to floor and it wasn't organized. They would take residents with them from floor to floor. This is not how you close a home. It was overwhelming and there were not a lot of department heads there. Housekeeping was on vacation, Human Resources was off. Before you knew it, people were gone. The halls were bombarded. Staff didn't "give a damn" over what she had to say. She was not going to get beat up over Owner A. She did not know who called 911 about the gas or the elevator. The Administrator called about the looting. With the elevator, you can't overload it or it will be stuck. When the DON left, she is not sure if she told the Administrator. Nurse J and the ADON said they would stay. She got there at 7:00 A.M. the next morning, the door was wide open. Only staff were in there, the Director of Maintenance, the person who runs the gift shop, activities and the receptionist. They were getting their things. Resident #10 had been on a leave of absence with family and he/she came back that morning.

During an interview on 12/18/23 at 9:16 A.M., Family Member (FM) M said the facility discharged his/her family member on Friday night, 12/15/23. FM M found this out from others in the facility, not a staff member. FM M was not contacted about the resident. FM M feels that the

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facility did him/her wrong.

During an interview on 12/18/23 at 10:30 A.M., FM N/Power of Attorney said the management staff never called him/her, to inform him/her the facility was being closed and where exactly the resident had been sent. He/She went to the facility on 12/16/23 and people were going in and getting things. FM N didn't go upstairs because he/she was scared.

During an interview on 12/20/23 at 2:00 P.M., FM O said the facility discharged two of his/her relatives with no notice, no medications, no personal belongings, and no paperwork.

2. Observation on 12/15/23 at 8:43 P.M., showed a "Code Green" was called overhead. Staff entered the Administrator's office and asked what that meant. She told them it was an elopement and said it was probably a particular resident. She did not call any of the units to determine who eloped and did not leave her office to investigate.

During an interview on 12/21/23 at 10:56 A.M., the DON said she didn't know who called the Code Green. The ADON, Nurse J and the DON were on the 4th floor. They looked and saw CNA K on 3, outside. She also looked outside and saw no one. She told staff to tell Nurse H to call the police and guardian. She believes the resident left with another home and no one noticed. Staff from other facilities were going from floor to floor.

During an interview on 12/15/23 at 9:47 P.M., Nurse H said Resident #1 eloped and they could not find him/her. They tried to call the guardian and also called 911.

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Review of the resident's record, showed the resident had a Legal Guardian/Public Administrator. The resident's diagnoses included arthritis, schizophrenia (a chronic brain with symptoms which can include delusions, hallucinations, disorganized speech, trouble with thinking and lack of motivation), psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality) and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs).

Observation on 12/15/23 at 9:55 P.M., showed the alarm sounding several times on the third floor. During an interview, Nurse H said it was the alarmed stairwell. He/She said people were going out of that stairwell, moving people. Multiple times, Nurse H said, "See what I mean." Staff did not respond to the stairwell.

Observation on 12/15/23 at 10:15 P.M., showed the alarm sounding loudly on the second floor. During an interview, Nurse I said he/she had been on duty since day shift. Nurse I could not identify how many residents were on the unit. Several representatives from other facilities read medical records, bagged medications from the medication carts, obtained medical records and resident belongings. Nurse I turned off the alarm. Staff did not respond to the alarm.

Observation on 12/15/23 at 10:27 P.M., showed Nurse I with an unsteady gait and limping. He/She said, "I gotta go" to no one in particular. The alarm continued to sound.

During an interview on 12/15/23 at 10:57 P.M.,

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the Marketing Director Resident #1 is delusional at baseline.

Review of the police report, dated 12/16/23 at 2:34 P.M., showed police responded to a gas station (7.4 miles from the facility), in reference to a check the welfare request. Police observed Resident #1 sitting on the ground on west side of the store with several shopping bags. The resident confirmed his/her name and he/she did not need any assistance, as he/she was waiting for a family member to pick him/her up. Police spoke with the resident's Legal Guardian who said the resident somehow walked away from the facility during the confusion. The Legal Guardian said the resident is not able to make his/her own medical decisions. He/She requested the resident be transported to the hospital for an evaluation, then he would make arrangements for the resident to be conveyed to another facility.

Review of the Emergency Room record, showed the following:
-12/16/23 at 4:27 P.M., patient brought to Emergency Department per Police Department from gas station after patient eloped from nursing facility. Patient expresses no acute complaints but is tangential with grandiose delusions.

During an interview on 12/21/23 at 2:05 P.M., the hospital Social Worker said the resident remained in the Emergency Department. Another facility accepted the resident, but required the resident to be free from aggression prior to admission.

3. Review of Resident #9's quarterly MDS, dated 8/3/23, showed:
-Severe cognitive impairment;
-Daily behavioral symptoms not directed towards

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others;
-Diagnoses included high blood pressure, diabetes mellitus and schizophrenia.

Review of the resident's care plan, showed:
-Problem Start Date: 02/08/2023: History of elopement. Resides on a Special Care Unit;
-Long Term Goal Target Date: 05/05/2023: Will remain safe and will not elope from facility over next 90 days;
-Approach: Encourage attendance in activities that provide recreation, physical exercise, or musical entertainment. If resident voices a desire to leave the facility, redirect him/her. Monitor per protocol. Immediately inform charge nurse and supervisor of any attempts to leave the facility unsupervised. Immediately initiate Code Green if unable to locate resident.
-Problem Start Date: 02/08/2023: Alteration in thought process (impaired memory, disorganized thinking, inattention, delusions, poor decision making, and bizarre behaviors) related to Schizophrenia and Borderline Personality Disorder. Leaves the water running in sink and becomes angry if staff turns it off. Removes the mattress from bed and sit/sleep on metal framing. Easily agitated. Displays verbally and physically aggressive behaviors towards others. History of throwing and destroying furniture and throwing items out of window. At risk for falls and other adverse side effects related to use of Psychotropic medications;
-Approach Start Date: 02/08/2023: Administer medication as ordered. Monitor for adverse side effects. Notify physician of behavior to assure lowest therapeutic dose is given. Encourage participation in activities which orient to reality and don't depend on orientation. Give simple choices. Assist with decision making as needed. Provide

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pleasant interaction which reassures resident when confused. Provide reality orientation, demonstration, cues, validation, and redirection as needed. Psychiatric consultation as ordered/indicated
-Long Term Goal Target Date: 05/05/2023: Will not harm self or others. Will remain safe and needs will be met daily. Will not have injury related to falls. Medication will have a therapeutic effect through next review.

During an interview on 12/21/23 at 10:56 A.M., the DON said she couldn't tell how Resident #9 got out. Staff think they have seen him/her around Natural Bridge and Kingshighway. She has told them to call the police. The resident has a guardian. The resident is oriented and has mental illness and poor decision making.

As of 1/5/2024, Resident #9's whereabouts are unknown.

4. Record review of the facility's list of residents and the location they were discharged, provided to DHSS employees on 12/16/23, showed 47 out of 174 residents were unaccounted for.

Record review of an email dated 12/16/23 at 1:17 PM, showed DHSS administration emailed CFO, Owner B's chief financial officer, and the registered agent for Northview Village, Inc, advising of resident medical information needed, concerns regarding residents relocated to Facility B and Facility C and the payroll status at those facilities and a second request for immediate contact. No response was received on 12/16/23.

During an interview on 12/17/23 at 1:22 PM, CFO and Owner A stated Northview Village would

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E 020	Continued From page 18 receive their Medicaid reimbursement check that week so they could pay employees. CFO stated the facility has been losing money for years and Owner A has been funding the losses. He had asked two financial backers in the operation to cover the payroll, however, they did not do so. During an interview on 12/21/23 at 10:56 A.M., the DON said staff were supposed to be paid on 12/22/23. They will be paid for vacation time and the following week next week. She still has had no response from Owner A. They had staffing problems and she told him recently they had to use agency staffing. They should have done this decently and in order.	E 020		
F 622 SS=F	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility.	F 622		

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Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving

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facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure transfer/discharge information, including medical records and appropriate information to provide care was communicated to the receiving health care institution or provider during an abrupt evacuation of the facility, due to staffing concerns created when employees were not paid. This affected all residents in the facility. The census was 174.

1. During an interview on 12/15/23 at 3:45 P.M., the Administrator said Owner A refused to pay

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staff, and said he did not have the money. The Chief Financial Officer (CFO) told the Administrator to contact Owner B to get the money for payroll. The administrator stated it was payday, and people were walking off shift. CFO told the Administrator to transfer as many residents as possible to Facility B and Facility C (under ownership of Owner A). At 4:50 P.M., the Administrator said their emergency preparedness plan had been enacted.

Observation on 12/15/23 at 6:00 P.M., showed multiple cars and vans on both sides of the street, adjacent to the facility's front entrance, making entry difficult.

During an interview on 12/15/23 at 6:30 P.M., two visitors said the phones were shut down. They tried to call the facility about their family member, but could not get through because the phones were down.

During an interview on 12/15/23 at 6:35 P.M., the Administrator said the phone lines were not down. The Administrator from Facility B was getting vehicles to move beds from this facility to Facility B. Someone from Facility B was calling families. Residents would be going to Facilities B, C, E and F.

Observation and interview on 12/15/23 at approximately 7:00 P.M., showed transportation staff from Facility G entered the administrator's office and offered to assist with placement of residents. The administrator told him/her that nobody was going to Facility G. The transportation staff then left the office. The Administrator said some residents would be transferred tonight, but some will not go until

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tomorrow.

Observation of the fifth floor on 12/15/23 at 7:07 P.M., showed a lot of activity on the floor, with representatives from other facilities reading medical records, bagging medications from the medication carts, obtaining medical records and resident belongings.

During an interview on 12/15/23 at 7:18 P.M., Resident #11 said nobody had said anything to him/her about moving and he/she did not want to move.

Observation of the fourth floor on 12/15/23 at 7:34 P.M., showed a lot of activity on the floor, with representatives from other facilities reading medical records, bagging medications from the medication carts, obtaining medical records and resident belongings. During an interview, the Assistant Director of Nursing (ADON) said there were 47 residents on the floor. Five residents left and a bunch more were leaving.

During an interview on 12/15/23 at approximately 7:38 P.M. Resident #12 said he/she did not know if he/she was leaving the facility or not. He/she was worried about getting his/her money from the resident trust account. The resident was tearful during the interview.

During an interview on 12/15/23 at approximately 7:40 P.M., the Administrator from Facility H said he/she had 15 skilled nursing facility beds available, but was told by the Administrator that all residents had been placed at this time.

During an interview on 12/15/23 at 7:49 P.M., Resident #13 said he/she did not know where

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he/she was going and may not be transferred to another facility until 12/18/23. That is what he was told by staff.

During an interview on 12/15/23, at approximately 10:00 P.M., the Admission Coordinator from Facility I said she was trying to help place residents at his/her skilled nursing facility, but it was "chaos" and resident charts were missing.

During an interview on 12/15/23 at 10:20 P.M., a representative of Facility D said Resident #2's medical record was taken by another facility, but the resident did not want to go to that facility. During an interview, Resident #2 said he/she was admitted at 4:00 P.M. that same day, and he/she was his/her own responsible party. He/She wanted to go to Facility D, and not to the facility who took his/her records.

During an interview on 12/15/23 at approximately 11:15 P.M., the Corporate Accounts Payable Staff Person J said 37 residents were going to be sent to local hospitals via Emergency Medical Services (EMS).

During an interview on 12/15/23 at 11:42 P.M., the Administrator said to her knowledge, there were 34 residents still in the building and they were all going to Facility B and Facility C.

Observation on 12/16/23 at 12:05 A.M., showed members of the fire department in the main lobby area of the building. During an interview at that time, one of the fire fighters said they were going to start on the 5th floor and work their way down, evacuating residents.

During an interview on 12/16/23 at 12:45 A.M.,

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the St. Louis EMS Chief said his goal was to evacuate the building.

During an interview on 12/16/23 at 12:50 A.M., Resident #14 said he/she wanted to go to Facility J.

During an interview on 12/16/23 at approximately 12:55 A.M., an EMS staff person said they were taking Resident #14 to Facility K, not Facility J. He/She added that it was very sad that these residents were leaving all of their belongings behind; their whole world.

During an interview on 12/16/23 at 1:25 A.M., Resident #15 said he/she was told he/she would be going to Facility L. He/She did not want to go there.

During an interview on 12/16/23 at approximately 1:27 A.M., Resident #16 said nobody had told him/her that he/she was going to be moving.

During an interview on 12/16/23 at 1:28 A.M., Resident #17 said nobody had told him/her that he/she was going to be moving.

During an interview on 12/16/23 at 2:30 A.M., the Administrator from Facility M said she had Resident #18's medical chart and medications, but another unknown facility took the resident to their facility. She said it was "a free for all up there."

Observation on 12/16/23 at 12:50 A.M., showed EMS assisting Resident #3 to a stretcher.

During an interview on 12/16/23 at 12:55 A.M., Resident #4 said he/she was really angry. At that

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time, the ADON was informed the resident requested assistance and was quite upset. The ADON responded, "when isn't (he/she)?" EMS entered the room a few minutes later, talking with the resident who continued to be upset.

Observation on 12/16/23 at 1:22 A.M., showed the last resident on second floor (Resident #5) refused to leave, and several EMS had to physically lift the resident to a stretcher, while he/she protested.

Observation on 12/16/23 at midnight through 5:30 A.M., showed multiple residents in the lobby. Several facilities were loading personal items in their vehicles, EMS transported residents on stretchers, and the City Police were onsite and secured the front desk. At 4:00 A.M., Resident #6 refused to leave, Resident #7 repeated concerns that his/her parents would not know where he/she was, and Resident #8 loudly refused to go. EMS administered two Haldol (antipsychotic) injections prior to several EMS lifting him/her to a stretcher. At 5:30 A.M., Resident #8 was the last resident to leave the facility.

Observation on 12/15-16/23, showed the Director of Nurses (DON) left the facility and did not return to any of the resident floors. The Administrator was not observed on the resident floors, including during the final floor sweeps conducted by the Fire Department. Observation showed the facility administrator not in charge of the evacuation process.

During an interview on 12/21/23 at 10:56 A.M., the DON said on Friday, 12/15/23, she started receiving calls at 5:30 A.M. about the paychecks

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and staff saying the money was not there. The DON was on the 4th floor at 3:00 P.M. when CMT D talked to the DON. They went to the Administrator's office. The Administrator said she would call a department head meeting. She had an email that was sent to her and the Corporate Nurse. They had exhausted all avenues and there were no paychecks. The DON didn't know who called the evacuation. The DON said she looked up and saw the Administrator and DON from Facility B there, and three staff from Facility C, and that someone had called the evacuation. She saw the Administrator and DON from Facility E there, then DHSS staff. She was unsure how to organize this. She left sick at 10:00 P.M. after she threw up. She knew it was her nerves. She saw other homes were there, and nurses sent by the Medical Director and Physician L. As homes came to see people, she told them they could look through the charts and then call their family members. They had notepads and the nurses were supposed to keep track of who was going where, but it was overwhelming. The facilities were pulling charts and not signing in. They were going floor to floor and it wasn't organized. They would take residents with them from floor to floor. This is not how you close a home. It was overwhelming. Before you knew it, people were gone.

Record review of an email dated 12/16/23 at 12:00 P.M. showed the Department of Mental Health reached out regarding a forensic client that was a resident at the facility. They had become aware that the home was abruptly closed and the clients were relocated and their Forensic Case Monitor was trying to determine where the client was now living.

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During an interview on 12/18/23 at 9:16 A.M., Family Member (FM) M said the facility discharged his/her family member on Friday night, 12/15/23. FM M found this out from others in the facility, not a staff member. FM M was not contacted about the resident. FM M feels that the facility "did (him/her) wrong".

During an interview on 12/18/23 at 10:30 A.M., FM N/Power of Attorney said the management staff never called him/her, to inform him/her the facility was being closed and where exactly the resident had been sent. He/She went to the facility on 12/16/23 and people were going in and getting things. FM N didn't go upstairs because he/she was scared.

During an interview on 12/20/23 at 2:00 P.M., FM O said the facility discharged two of his/her relatives with no notice, no medications, no personal belongings and no paperwork.

Record review of an email from a resident advocate dated 12/20/23 at 12:25 P.M., showed the following: The past few days our staff and volunteers visited almost 20 nursing homes that Northview residents were transferred to. While a few of them are okay with their new homes, the rest are sad, panicked, stressed, confused... and mostly, very angry. The majority of these residents did not have much to begin with; now they literally have nothing. A few residents talked with a blanket covering themselves as they were moved to their new home without even a pair of pants. A couple of lucky residents got their TV (but not remotes), and some just curled up into a ball sobbing and refusing to speak with us. The questions we most encountered were who to complain to and how to get their belongings (and

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F 689 SS=J	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 observation, interview and record review, the facility failed to ensure resident safety during the evacuation of the facility. Two residents, who had appointed legal guardians, eloped (Residents #1 and #9) from the facility. Staff did not respond to safety alarms as they sounded. In addition, the phone line was cut, security staff were not present, an elevator was overcrowded and stuck for 30 minutes with residents inside, medications were not distributed orderly and staff were not present on halls where two residents were residing (Residents #7 and #3). The census was 174.	F 689		

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1. Review of an email dated 12/15/23 at 2:27 P.M., showed the ownership's Chief Financial Officer (CFO) told the Administrator: "After a long fight to get the ownership to fund Northview's continuing losses, I, nor (Owner A) have been able to get funds from the other part of the ownership group for Northview. Owner A is not able to fund this as he has exhausted everything he has from funding his homes for so long. I am not sure what to say as I have had many solutions to get us through our cash flow issues, but I do not have a solution this week. I spoke to Owner A and he suggested that you give employees Owner B's office information as we were expecting funds from him and he is not budging."

During an interview on 12/15/23 at 3:45 P.M., the Administrator said Owner A refused to pay staff, and said he did not have the money. CFO told the Administrator to contact Owner B to get the money for payroll. This is payday, and people are walking off shift. CFO told the Administrator to transfer as many residents as possible to Facility B and Facility C (which Owner A also owns). At 4:50 P.M., the Administrator said their emergency preparedness plan had been enacted.

Observation on 12/15/23 at 6:00 P.M., showed multiple cars and vans on both sides of the street, adjacent to the facility's front entrance, making entry difficult. Staff were outside and inside the front lobby, including a security guard. A staff member, outside the facility yelled, "agency staff are paid, but they don't pay us".

During an interview on 12/15/23 at 6:15 P.M., Licensed Practical Nurse (LPN) C said all day, administration said staff would be paid. When

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they found out they would not be paid, staff came in for work and turned around and left.

During an interview on 12/15/23 at 6:20 P.M., Certified Medication Technician (CMT) D said she talked with the Administrator about 3:10 P.M. and the Administrator showed CMT D the letter on her computer, saying staff would not be paid.

During an interview on 12/15/23 at 6:30 P.M., two visitors said the phones were shut down. They tried to call the facility about their family member, but could not get through because the phones were down.

During an interview on 12/15/23 at 6:35 P.M., the Administrator said the phone lines were not down. The Administrator from Facility B was getting vehicles to move beds from Northview to Facility B. Someone from Facility B was calling families. The Administrator said there were staff on all floors, including agency staff, taking care of the residents. Agency staff had been paid, so she knew they were staying in the building. She said staff were looting and someone stole gas from the facility van. The Administrator said she had been threatened. Residents would be going to Facilities B, C, E and F.

Observation of the fifth floor on 12/15/23 at 7:07 P.M., showed one agency LPN (LPN F), one CMT and one agency Certified Nurse Aide (CNA G) on duty. There was a lot of activity on the floor, with representatives from other facilities reading medical records, bagging medications from the medication carts, obtaining medical records and resident belongings. During an interview, the agency LPN said there was no security tonight, so his/her agency told her to

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leave for his/her own safety. He/She would be leaving in a few minutes. CNA G said he/she was on duty until 7:00 A.M.

Observation of the fourth floor on 12/15/23 at 7:34 P.M., showed three CNAs, one CMT and the Assistant Director of Nurses (ADON). There was a lot of activity on the floor, with representatives from other facilities reading medical records, bagging medications from the medication carts, obtaining medical records and resident belongings. During an interview, the ADON said there were 47 residents on the floor. Five residents had already left and a bunch more were leaving. The elevator near the nurses station became stuck, with people trapped on it.

During an interview on 12/15/23 at 8:00 P.M., the Administrator said she was unaware the elevator was stuck.

During an interview on 12/15/23 at 8:25 P.M., a fireman said the elevator had too many people in it and that was why it was stuck. There had been 9 people on it. At that time, a family member said they were on the stuck elevator for 30 minutes, and that included his/her family member, who was in a wheelchair. At that time, two utility workers entered the facility, for a report of a potential gas leak/gas odor in the kitchen.

Observation on 12/15/23 at 8:25 P.M., showed no security on duty at the front desk.

During an interview on 12/15/23, at approximately 10:00 P.M., the Admission Coordinator from Facility I said she was trying to help place residents at his/her skilled nursing facility, but it was "chaos" and resident charts were missing.

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Observation on 12/15/23 at 10:15 P.M., showed the stairwell security alarm sounding loudly on the second floor. During an interview, Nurse I said he/she had been on duty since day shift. Nurse I could not identify how many residents were on the unit. Several representatives from other facilities read medical records, bagged medications from the medication carts, obtained medical records and resident belongings. Nurse I turned off the alarm. Staff did not respond to the alarm.

During an interview on 12/15/23 at approximately 11:15 P.M., the Corporate Accounts Payable Staff Person J said 37 residents were going to be sent to local hospitals via Emergency Medical Services (EMS).

Observation on 12/15/23 at 11:15 P.M., showed three residents remained on the fifth floor. Two people identified themselves as volunteers on the floor. At that time, a representative from a home health agency, who had previously been on other units, walked freely on the floor. At 11:18 P.M., an alarm continued to sound. The two volunteers said they were not previously known volunteers of the facility and showed up to help.

During an interview on 12/15/23 at 11:30 P.M., the Administrator said she did not know of any volunteers on any of the units, nor was she aware of the home health agency representative on the floor. She and the Marketing Director went to the fifth floor at that time, and she said she would "take care of" him/her. At 11:42 P.M., the Administrator said to her knowledge, there were 34 residents still in the building and they were all going to Facility B and Facility C. At 11:48 P.M.,

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the Administrator said the Internet and phone worked. The Marketing Director informed her the phones did not work and there was no security on duty. The Administrator verified the phone lines did not work.

Observation on 12/16/23 at 12:05 A.M., showed members of the fire department in the main lobby area of the building. During an interview at that time, one of the fire fighters said they were going to start on the fifth floor and work their way down, evacuating residents.

During an interview on 12/16/23 at 12:45 A.M., the St. Louis EMS Chief said his goal was to evacuate the building.

During an interview on 12/16/23 at 2:30 A.M., the Administrator from Facility M said she had Resident #18's medical chart and medications, but another unknown facility took the resident to their facility. She said it was "a free for all up there."

Observation on 12/16/23 at 4:10 A.M., showed Resident #7 was the only person on the 3rd floor. He/she lay in his/her bed. Observation at 4:12 A.M., showed an unknown female staff person exited the elevator onto the floor. He/She said everyone was off of the floor at that time. When told Resident #7 was in his/her room, the staff person said he/she did not realize anyone was left on the floor.

Observation on 12/16/23 at 12:50 A.M., showed EMS assisting Resident #3 to a stretcher. No staff were on the fifth-floor unit, where he/she resided.

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During an interview on 12/16/23 at 12:55 A.M., Resident #4 said he/she was really wet and had been for over an hour. He/She said he/she was really angry. At that time, the ADON was informed the resident requested assistance and was quite upset. The ADON responded, "when isn't (he/she)?" EMS entered the room a few minutes later, talking with the resident who continued to be upset. Two other residents were in bed, and a third resident ambulated in the hallway with a representative from another facility.

Observation on 12/16/23 at 1:22 A.M., showed 16 residents on the third floor. One nurse was on the floor. Two residents and Nurse I remained on the second floor. The last resident on second floor (Resident #5) refused to leave, and several EMS had to physically lift the resident to a stretcher, while he/she protested.

Observation on 12/16/23 at midnight through 5:30 A.M., showed multiple residents in the lobby. Several facilities were loading personal items in their vehicles, EMS was transporting residents on stretchers, and the City Police were onsite and secured the front desk. At approximately 5:00 A.M., Resident #6 refused to leave, Resident #7 repeated concerns that his/her parents would not know where he/she was, and Resident #8 loudly refused to go. EMS administered two Haldol (antipsychotic) injections prior to several EMS lifting Resident #8 to a stretcher. At approximately 5:45 A.M., Resident #8 was the last resident to leave the facility.

Review of Resident #8's face sheet, showed his/her diagnoses included cognitive communication deficit (an impairment in organization/ thought organization, sequencing,

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attention, memory, planning, problem-solving and safety awareness), anxiety disorder, schizoaffective disorder (a chronic mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions, and symptoms of a mood disorder, such as mania and depression), persistent mood disorder and intellectual disabilities.

Observation on 12/15-16/23, showed the DON left the facility and did not return to any of the resident floors. The Administrator was not observed assisting on the floors at any time, including the final floor sweeps conducted by the Fire Department.

During an interview on 12/21/23 at 10:56 A.M., the DON said she went out front and called the police twice herself. She also tried to call the floors and couldn't get through. The phone lines were cut. She doesn't know who cut them. She said she left sick at 10:00 PM after she threw up. She knew it was her nerves. She saw other homes were there, and nurses sent by the medical director and another physician. As homes came to see people, she told them they could look through the charts and then call their family members. They had notepads and the nurses were supposed to keep track of who was going where, but it was overwhelming. The facilities were pulling charts and not signing in. They were going floor to floor and it wasn't organized. They would take residents with them from floor to floor. This is not how you close a home. It was overwhelming and there were not a lot of department heads there. Before you knew it, people were gone.

2. Observation on 12/15/23 at 8:43 P.M., showed

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a "Code Green" was called overhead. Facility B staff entered the Administrator's office and asked what that meant. She told them it was an elopement and said it was probably a particular resident. She did not call any of the units to determine who eloped and did not leave her office to investigate.

During an interview on 12/15/23 at 9:47 P.M., Nurse H said Resident #1 eloped and they could not find him/her. They tried to call the guardian and also called 911.

During an interview on 12/21/23 at 10:56 A.M., the DON said she didn't know who called the Code Green. The ADON, Nurse J and the DON were on the fourth floor. They looked and saw CNA K outside. The DON also looked outside and saw no one. She told staff to tell Nurse H to call the police and guardian. She believes the resident left with another home and no one noticed. She stated staff from other facilities were going from floor to floor. The resident is alert and oriented time three to four (person, place, time and situation).

Observation on 12/15/23 at 9:55 P.M., showed the alarm sounding several times on the third floor. During an interview, Nurse H said it was the alarmed stairwell. He/She said people were going out of that stairwell, moving people. Multiple times, Nurse H said, "See what I mean?" Staff did not respond to the stairwell to determine who was leaving the floor.

During an interview on 12/15/23 at 10:57 P.M., the Marketing Director said Resident #1 is delusional at baseline.

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Review of the resident's record, showed the resident had a legal guardian/public administrator. The resident's diagnoses included arthritis, schizophrenia (a chronic brain with symptoms which can include delusions, hallucinations, disorganized speech, trouble with thinking and lack of motivation), psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality) and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs).

Review of the police report, dated 12/16/23 at 2:34 P.M., showed police responded to a gas station (7.4 miles from the facility), in reference to a check the welfare request. Police observed Resident #1 sitting on the ground on the west side of the store with several shopping bags. The resident confirmed his/her name and he/she did not need any assistance, as he/she was waiting for a family member to pick him/her up. Police spoke with the resident's legal guardian who said the resident somehow walked away from the facility during the confusion. The legal guardian said the resident is not able to make his/her own medical decisions. He/She requested the resident be transported to the hospital for an evaluation, then he would make arrangements for the resident to be conveyed to another facility.

Review of the Emergency Room record, showed the following:
-12/16/23 at 4:27 P.M., patient brought to Emergency Department (ED) per Police Department(PD) from gas station after patient eloped from nursing facility. Patient expresses no acute complaints but is tangential (erratic) with grandiose delusions.

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3. Review of Resident #9's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 8/3/23, showed staff assessed the resident as:
-Severe cognitive impairment;
-Daily behavioral symptoms not directed towards others;
-Diagnoses included high blood pressure, diabetes mellitus and schizophrenia.

Review of the resident's care plan, showed:
-Problem Start Date: 02/08/2023: History of elopement. Resides on a Special Care Unit;
-Long Term Goal Target Date: 05/05/2023: Will remain safe and will not elope from facility over next 90 days;
-Approach: Encourage attendance in activities that provide recreation, physical exercise, or musical entertainment. If resident voices a desire to leave the facility, redirect him/her. Monitor per protocol. Immediately inform charge nurse and supervisor of any attempts to leave the facility unsupervised. Immediately initiate Code Green if unable to locate resident.
-Problem Start Date: 02/08/2023: Alteration in thought process (impaired memory, disorganized thinking, inattention, delusions, poor decision making, and bizarre behaviors) related to Schizophrenia and Borderline Personality Disorder. Leaves the water running in sink and becomes angry if staff turns it off. Removes the mattress from bed and sit/sleeps on metal framing. Easily agitated. Displays verbally and physically aggressive behaviors towards others. History of throwing and destroying furniture and throwing items out of window. At risk for falls and other adverse side effects related to use of Psychotropic medications;

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F 689	Continued From page 39 -Approach Start Date: 02/08/2023: Administer medication as ordered. Monitor for adverse side effects. Notify physician of behavior to assure lowest therapeutic dose is given. Encourage participation in activities which orient to reality and don't depend on orientation. Give simple choices. Assist with decision making as needed. Provide pleasant interaction which reassures resident when confused. Provide reality orientation, demonstration, cues, validation, and redirection as needed. Psychiatric consultation as ordered/indicated -Long Term Goal Target Date: 05/05/2023: Will not harm self or others. Will remain safe and needs will be met daily. Will not have injury related to falls. Medication will have a therapeutic effect through next review. During an interview on 12/21/23 at 10:56 A.M., the DON said she couldn't tell how Resident #9 "got out". Staff think they have seen him/her around Natural Bridge and Kingshighway. She has told them to call the police. The resident has a guardian. He/She is oriented. He/She has mental illness and poor decision making. As of 1/5/24, Resident #9's whereabouts are unknown.	F 689		
F 835 SS=L	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced	F 835		

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by:
Based on observation, interview and record review, the facility administration failed to operate and administer the facility in a manner that used its resources effectively and efficiently to ensure residents attained or maintained their highest practicable physical, mental, and psychosocial well-being. The facility operators failed to pay the employees of the facility on 12/15/23, negatively impacting resident safety when insufficient staff were present to provide adequate resident care. Due to safety concerns, the facility administration decided to emergently evacuate the building. The facility administration failed to evacuate the residents in an orderly, organized manner, which included finding placement and transportation for residents, sending residents' medical records and medications in an orderly manner, and notification to the resident representatives. One resident was administered Haldol (an antipsychotic) intramuscularly, because he/she was so visibly upset and adamantly refused to leave (Resident #8). Two residents with legal guardians eloped from the facility during the evacuation (Residents #1 and #9). The failures jeopardized the health and safety of all residents and staff. The census was 174.

Review of the emergency procedures showed they were updated and signed by the Administrator on 11/15/23.
-Purpose: to set forth basic responsibilities and outline actions to be taken to protect life, provide resident care and protect property in this nursing home during man-made and natural disaster situations;
-Situation-A local disaster, such as fire, high winds, tornado, explosion, earthquakes, utility outage, terrorism, floods etc may occur at any

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time and affect this nursing home;
-Responsibility for Coordinating Emergency Actions (Administrator):
-2. Assumes control of enacting emergency actions within the nursing home;
-3. Assigns tasks to emergency staff;
-4. Augments departmental staff with any available personnel;
-5. Directs recall of off duty personnel;
-7. Order evacuation of the nursing home if necessary.
-Staff walkout was not identified or addressed in the emergency procedures.

1. Record review of Affiliate List received on 4/9/2019, for the operator of the facility, Northview Village, Inc., showed Owner A, Owner B, and Owner C listed as officers and directors of the corporation.

Record review of the Affiliate List received 3/27/2023, for the ownership of the land of building, Northview Village Center Limited Partnership, showed the following for limited partners:
- Owner A and C joint owners with 51% interest;
- Owner B with 39.543% interest; and
- Owner D with 9.457% interest.

Record review of an email dated 12/15/23 at 2:27 PM, showed the ownership's Chief Financial Officer (CFO) told the Administrator: "After a long fight to get the ownership to fund Northview's continuing losses, I, nor (Owner A) have been able to get funds from the other part of the ownership group for Northview. (Owner A) is not able to fund this as he has exhausted everything he has from funding his homes for so long. I am not sure what to say as I have had many

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solutions to get us through our cash flow issues, but I do not have a solution this week. I spoke to (Owner A) and he suggested that you give employees (Owner B's) office information as we were expecting funds from him and he is not budging."

During an interview on 12/15/23 at 3:45 P.M., the Administrator said Owner A refused to pay staff, and said he did not have the money. The CFO told the Administrator to contact Owner B to get the money for payroll. The administrator stated is was payday, and people were walking off shift. CFO told the Administrator to transfer as many residents as possible to Facility B and Facility C (under ownership of Owner A). At 4:50 P.M., the Administrator said their emergency preparedness plan had been enacted.

Record review of an email dated 12/15/23 at 5:14 PM, showed Department of Health & Senior Services (DHSS) administration emailed CFO, Owner B's chief financial officer, and the registered agent for Northview Village, Inc, requesting immediate contact due to payroll not being funded, putting over 170 residents at immediate risk. No response was received on 12/15/23.

Observation on 12/15/23 at 6:00 P.M., showed multiple cars and vans on both sides of the street, adjacent to the facility's front entrance, making entry difficult. Staff were outside and inside the front lobby, including a security guard.

During an interview on 12/15/23 at 6:15 P.M., Licensed Practical Nurse (LPN) C said she has worked at the facility for 13 years. She said paychecks were late three or four times before.

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All day, administration said staff would be paid. When they found out they would not be paid, staff came in for work and turned around and left.

During an interview on 12/15/23 at 6:20 P.M., Certified Medication Technician (CMT) D said she worked at the facility for 37 years. He/She talked with the Administrator about 3:10 P.M. and she showed CMT D the letter on her computer, saying staff would not be paid.

During an interview on 12/15/23 at 6:25 P.M., Certified Nurse Aide (CNA) E said a problem getting paid late had happened before, but they were always paid before.

During an interview on 12/15/23 at 6:30 P.M., two visitors said the phones were shut down. They tried to call the facility about their family member, but could not get through because the phones were down.

During an interview on 12/15/23 at 6:35 P.M., the Administrator said the phone lines were not down. The Administrator from Facility B was getting vehicles to move beds from this facility to Facility B. Someone from Facility B was calling families. The Administrator said there were staff on all floors, including agency staff, taking care of the residents. Agency staff had been paid, so she knew they were staying in the building. She said staff were looting and someone stole gas from the facility van. All residents were still in the facility. The Administrator said she had been threatened. Residents would be going to Facilities B, C, E and F.

Observation and interview on 12/15/23 at approximately 7:00 P.M., showed transportation

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staff from Facility G entered the administrator's office and offered to assist with placement of residents. The administrator told him/her that nobody was going to Facility G. The transportation staff then left the office. The Administrator said some residents would be transferred tonight, but some will not go until tomorrow.

Observation of the fifth floor on 12/15/23 at 7:07 P.M., showed one agency LPN (LPN F), one CMT and one agency CNA (CNA G) on duty. There was a lot of activity on the floor, with representatives from other facilities reading medical records, bagging medications from the medication carts, bagging medical records and resident belongings. During an interview, the agency LPN said there was no security tonight, so his/her agency told her to leave for his/her own safety. He/She would be leaving in a few minutes. CNA G said he/she was on duty until 7:00 A.M.

During an interview on 12/15/23 at 7:18 P.M., Resident #11 said nobody had said anything to him/her about moving and he/she did not want to move.

Observation of the fourth floor on 12/15/23 at 7:34 P.M., showed three CNAs, one CMT and the Assistant Director of Nurses (ADON). There was a lot of activity on the floor, with representatives from other facilities reading medical records, bagging medications from the medication carts, obtaining medical records and resident belongings. During an interview, the ADON said there were 47 residents on the floor. Five residents left and a bunch more were leaving. The elevator near the nurses station became

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stuck, with people trapped on it.

During an interview on 12/15/23 at approximately 7:38 P.M. Resident #12 said he/she did not know if he/she was leaving the facility or not. He/she was worried about getting his/her money from the resident trust account. The resident was tearful during the interview.

During an interview on 12/15/23 at approximately 7:40 P.M., the Administrator from Facility H said he/she had 15 skilled nursing facility beds available, but was told by the Administrator that all residents had been placed at this time.

During an interview on 12/15/23 at 7:49 P.M., Resident #13 said he/she did not know where he/she was going and may not be transferred to another facility until 12/18/23. That is what he was told by staff.

During an interview on 12/15/23 at 8:00 P.M., the Administrator said she was unaware the elevator was stuck and that she and the Director of Nursing (DON) would be in the facility the following day.

During an interview on 12/15/23 at 8:25 P.M., a fireman said the elevator had too many people in it and that was why it was stuck. There had been nine people on it. At that time, a family member said they were on the stuck elevator for 30 minutes, and that included his/her family member, who was in a wheelchair. At that time, two utility workers entered the facility, for a report of a potential gas leak/gas odor in the kitchen.

Observation on 12/15/23 at 8:25 P.M., showed no security were on duty at the front desk.

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During an interview on 12/15/23, at approximately 10:00 P.M., the Admission Coordinator from Facility I said she was trying to help place residents at his/her skilled nursing facility, but it was "chaos" and resident charts were missing.

During an interview on 12/15/23 at 10:20 P.M., a representative of Facility D said Resident #2's medical record was taken by another facility, but the resident did not want to go to that facility. During an interview, Resident #2 said he/she was admitted at 4:00 P.M. that same day, and he/she was his/her own responsible party. He/She wanted to go to Facility D, and not to the facility who took his/her records.

During an interview on 12/15/23 at approximately 11:15 P.M., the Corporate Accounts Payable Staff Person J said 37 residents were going to be sent to local hospitals via Emergency Medical Services (EMS).

Observation on 12/15/23 at 11:15 P.M., showed three residents remained on the fifth floor. Two people identified themselves as volunteers on the floor. At that time, a representative from a home health agency, who had previously been on other units, walked freely on the floor. At 11:18 P.M., an alarm continued to sound. The two volunteers said they were not previously known volunteers of the facility and showed up to help.

During an interview on 12/15/23 at 11:30 P.M., the Administrator said she did not know of any volunteers on any of the units, nor was she aware of the home health agency representative on the floor. She and the Marketing Director went to the fifth floor at that time, and she said she would

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"take care of" him/her. At 11:42 P.M., the Administrator said to her knowledge, there were 34 residents still in the building and they were all going to Facility B and Facility C. At 11:48 P.M., the Administrator said the Internet and phone worked. The Marketing Director informed her the phones did not work and there was no security on duty. The Administrator verified the phone lines did not work.

Observation on 12/16/23 at 12:05 A.M., showed members of the fire department in the main lobby area of the building. During an interview at that time, one of the fire fighters said they were going to start on the 5th floor and work their way down, evacuating residents.

During an interview on 12/16/23 at 12:45 A.M., the St. Louis EMS Chief said his goal was to evacuate the building.

During an interview on 12/16/23 at 12:50 A.M., Resident #14 said he/she wanted to go to Facility J.

During an interview on 12/16/23 at approximately 12:55 A.M., an EMS staff person said they were taking Resident #14 to Facility K, not Facility J. He/She added that it was very sad that these residents were leaving all of their belongings behind; their whole world.

During an interview on 12/16/23 at 1:25 A.M., Resident #15 said he/she was told he/she would be going to Facility L. He/She did not want to go there.

During an interview on 12/16/23 at approximately 1:27 A.M., Resident #16 said nobody had told

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him/her that he/she was going to be moving.

During an interview on 12/16/23 at 1:28 A.M., Resident #17 said nobody had told him/her that he/she was going to be moving.

During an interview on 12/16/23 at 2:30 A.M., the Administrator from Facility M said she had Resident #18's medical chart and medications, but another unknown facility took the resident to their facility. She said it was "a free for all up there."

Observation on 12/16/23 at 4:10 A.M., showed Resident #7 was the only person on the third floor. He/She lay in his/her bed. Observation at 4:12 A.M., showed an unknown female staff person exited the elevator onto the floor. He/She said everyone was off of the floor at that time. When told Resident #7 was in his/her room, the staff person said he/she did not realize anyone was left on the floor.

Observation on 12/16/23 at 12:50 A.M., showed EMS assisting Resident #3 to a stretcher. No staff were on the fifth-floor unit, where he/she resided.

During an interview on 12/16/23 at 12:55 A.M., Resident #4 said he/she was really wet and had been for over an hour. He/She said he/she was really angry. At that time, the ADON was informed the resident requested assistance and was quite upset. The ADON responded, "when isn't (he/she)?" EMS entered the room a few minutes later, talking with the resident who continued to be upset. Two other residents were in bed, and a third resident ambulated in the hallway with a representative from another facility.

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Observation on 12/16/23 at 1:22 A.M., showed 8 residents on the third floor. One nurse was on the floor. Two residents and Nurse I remained on the second floor. The last resident on second floor (Resident #5) refused to leave, and several EMS had to physically lift the resident to a stretcher, while he/she protested. Nurse I did not assist with the transfer.

Observation on 12/16/23 at midnight through 5:30 A.M., showed multiple residents in the lobby. Several facilities were loading personal items in their vehicles, EMS transported residents on stretchers, and the City Police were onsite and secured the front desk. At 4:00 A.M., Resident #6 refused to leave, Resident #7 repeated concerns that his/her parents would not know where he/she was, and Resident #8 loudly refused to go. EMS administered two Haldol (antipsychotic) injections prior to several EMS lifting him/her to a stretcher. At 5:30 A.M., Resident #8 was the last resident to leave the facility.

Review of Resident #8's face sheet, showed his/her diagnoses included cognitive communication deficit (an impairment in organization/ thought organization, sequencing, attention, memory, planning, problem-solving and safety awareness), anxiety disorder, schizoaffective disorder (a chronic mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions, and symptoms of a mood disorder, such as mania and depression), persistent mood disorder and intellectual disabilities.

Observation on 12/15-16/23, showed the DON

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left the facility and did not return to any of the resident floors. The Administrator was not observed on the resident floors, including during the final floor sweeps conducted by the Fire Department. Observation showed the facility administrator not in charge of the evacuation process.

During an interview on 12/21/23 at 10:56 A.M., the DON said on Friday, 12/15/23, she started receiving calls at 5:30 A.M. about the paychecks and staff saying the money was not there. She tried to get staff to calm down. She checked her own account at 6:00 A.M. and hers was not there either. This is the third time this year. The other two times they were paid late. The DON went into work. The DON talked to the Administrator at the elevator and told her this was now the third time. They went up, and met in the office-herself, the Administrator and the ADON. The Administrator said she had an email from CFO per Owner A saying she needed to call the other two owners about making payroll. After the Administrator read it, Owner A called the Administrator and asked her if she called them. Owner A said, you need to call and email them. The Administrator refused to call or email the other owners and told him he needed to tell her what to tell people about their pay. The Administrator told the DON to tell staff they were working on it. The first time this happened, paper checks were sent. The second time, the money was wired through and everyone got their money, but at different times. About 12:00 P.M., the DON came down and asked the status. The staff were ok on day shift and everyone worked normally and did their jobs. No one was "wigging out". The DON was on the 4th floor at 3:00 P.M. when CMT D talked to the DON. They went to the

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Administrator's office. CMT D asked the Administrator about it and the Administrator said, you know what I know. The Administrator said she would call a department head meeting. She had an email that was sent to her and the Corporate Nurse. They had exhausted all avenues and there were no paychecks. The CFO was blaming the other two owners and the other two owners wouldn't pay. They gave them nothing to tell the staff. The Administrator gave out the phone numbers of the owner, they printed it and handed it out. When staff called the numbers, they were hanging up on them. The DON also called Owner A and left a message. Everything "went left". Dayshift was outside. Some were also in the lobby. Some staff were quiet and others were not. The DON doesn't know who called the evacuation. Once she saw evening shift was there, she was ok with that. She went out front and she called the police twice herself. She also tried to call the floors and couldn't get through. The phone lines were cut. She did not know who cut them. The DON knows she looked up and saw the Administrator and DON from Facility B there, and three staff from Facility C, and that someone had called the evacuation. She saw the Administrator and DON from Facility E there, then DHSS staff. She was unsure how to organize this. She left sick at 10:00 P.M. after she threw up. She knew it was her nerves. She saw other homes were there, and nurses sent by the Medical Director and Physician L. There was a nurse on each floor. As homes came to see people, she told them they could look through the charts and then call their family members. They had notepads and the nurses were supposed to keep track of who was going where, but it was overwhelming. The facilities were pulling charts and not signing in.

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They were going floor to floor and it wasn't organized. They would take residents with them from floor to floor. This is not how you close a home. It was overwhelming and there were not a lot of department heads there. Housekeeping was on vacation. Human Resources was off. Before you knew it, people were gone. The halls were bombarded. Staff didn't "give a damn" over what she had to say. She was not going to get beat up over Owner A. She did not know who called 911 about the gas or the elevator. The Administrator called about the looting. With the elevator, you can't overload it or it will be stuck. When the DON left, she is not sure if she told the Administrator. Nurse J and the ADON said they would stay. She got there at 7:00 A.M. the next morning, the door was wide open. Only staff were in there, the Director of Maintenance, the person who runs the gift shop, activities and the receptionist. They were getting their things. Resident #10 had been on a leave of absence with family and he/she came back that morning.

During an interview on 12/18/23 at 9:16 A.M., Family Member (FM) M said the facility discharged his/her family member on Friday night, 12/15/23. FM M found this out from others in the facility, not a staff member. FM M was not contacted about the resident. FM M feels that the facility did him/her wrong.

During an interview on 12/18/23 at 10:30 A.M., FM N/Power of Attorney said the management staff never called him/her, to inform him/her the facility was being closed and where exactly the resident had been sent. He/She went to the facility on 12/16/23 and people were going in and getting things. FM N didn't go upstairs because he/she was scared.

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During an interview on 12/20/23 at 2:00 P.M., FM O said the facility discharged two of his/her relatives with no notice, no medications, no personal belongings and no paperwork.

Observation on 12/15/23 at 9:55 P.M., showed the alarm sounding several times on the third floor. During an interview, Nurse H said it was the alarmed stairwell. He/She said people were going out of that stairwell, moving people. Multiple times, Nurse H said, "See what I mean.?" Staff did not respond to the stairwell.

Observation on 12/15/23 at 10:15 P.M., showed the alarm sounding loudly on the second floor. During an interview, Nurse I said he/she had been on duty since day shift. Nurse I could not identify how many residents were on the unit. Several representatives from other facilities read medical records, bagged medications from the medication carts, obtained medical records and resident belongings. Nurse I turned off the alarm. Staff did not respond to the alarm.

Observation on 12/15/23 at 10:27 P.M., showed Nurse I with an unsteady gait and limping. He/She said, "I gotta go" to no one in particular. The alarm continued to sound.

2. Observation on 12/15/23 at 8:43 P.M., showed a "Code Green" was called overhead. Staff entered the Administrator's office and asked what that meant. She told them it was an elopement and said it was probably a particular resident. She did not call any of the units to determine who eloped and did not leave her office to investigate.

During an interview on 12/15/23 at 9:47 P.M.,

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Nurse H said Resident #1 eloped and they could not find him/her. They tried to call the guardian and also called 911.

During an interview on 12/21/23 at 10:56 A.M., the DON said she didn't know who called the Code Green. The ADON, Nurse J and the DON were on the 4th floor. They looked and saw CNA K on 3, outside. She also looked outside and saw no one. She told staff to tell Nurse H to call the police and guardian. She believes the resident left with another home and no one noticed. Staff from other facilities were going from floor to floor.

Review of the resident's record, showed the resident had a Legal Guardian/Public Administrator. The resident's diagnoses included arthritis, schizophrenia (a chronic brain with symptoms which can include delusions, hallucinations, disorganized speech, trouble with thinking and lack of motivation), psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality) and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs).

During an interview on 12/15/23 at 10:57 P.M., the Marketing Director said Resident #1 is delusional at baseline.

Review of the police report, dated 12/16/23 at 2:34 P.M., showed police responded to a gas station (7.4 miles from the facility), in reference to a check the welfare request. Police observed the Resident #1 sitting on the ground on west side of the store with several shopping bags. The resident confirmed his/her name and he/she did

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not need any assistance, as he/she was waiting for a family member to pick him/her up. Police spoke with the resident's Legal Guardian who said the resident somehow walked away during the confusion. The Legal Guardian said the resident is not able to make his/her own medical decisions. He/She requested the resident be transported to the hospital for an evaluation, then he would make arrangements for the resident to be conveyed to another facility.

Review of the Emergency Room record, showed the following:
-12/16/23 at 4:27 P.M., patient brought to Emergency Department per Police Department from gas station after patient eloped from nursing facility. Patient expresses no acute complaints but is tangential with grandiose delusions.

During an interview on 12/21/23 at 2:05 P.M., the hospital Social Worker said the resident remained in the Emergency Department. Another facility accepted the resident, but required the resident to be free from aggression prior to admission.

3. Review of Resident #9's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 8/3/23, showed staff assessed the resident as:
-Severe cognitive impairment;
-Daily behavioral symptoms not directed towards others;
-Diagnoses included high blood pressure, diabetes mellitus and schizophrenia.

Review of the resident's care plan, showed:
-Problem Start Date: 02/08/2023: History of elopement. Resides on a Special Care Unit;
-Long Term Goal Target Date: 05/05/2023: Will

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remain safe and will not elope from facility over next 90 days;
-Approach: Encourage attendance in activities that provide recreation, physical exercise, or musical entertainment. If resident voices a desire to leave the facility, redirect him/her. Monitor per protocol. Immediately inform charge nurse and supervisor of any attempts to leave the facility unsupervised. Immediately initiate Code Green if unable to locate resident.
-Problem Start Date: 02/08/2023: Alteration in thought process (impaired memory, disorganized thinking, inattention, delusions, poor decision making, and bizarre behaviors) related to Schizophrenia and Borderline Personality Disorder. Leaves the water running in sink and become angry if staff turns it off. Removes the mattress from bed and sit/sleep on metal framing. Easily agitated. Displays verbally and physically aggressive behaviors towards others. History of throwing and destroying furniture and throwing items out of window. At risk for falls and other adverse side effects related to use of Psychotropic medications;
-Approach Start Date: 02/08/2023: Administer medication as ordered. Monitor for adverse side effects. Notify physician of behavior to assure lowest therapeutic dose is given. Encourage participation in activities which orient to reality and don't depend on orientation. Give simple choices. Assist with decision making as needed. Provide pleasant interaction which reassures resident when confused. Provide reality orientation, demonstration, cues, validation, and redirection as needed. Psychiatric consultation as ordered/indicated
-Long Term Goal Target Date: 05/05/2023: Will not harm self or others. Will remain safe and needs will be met daily. Will not have injury

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related to falls. Medication will have a therapeutic effect through next review.

During an interview on 12/21/23 at 10:56 A.M., the DON said she couldn't tell how Resident #9 "got out". Staff think they have seen him/her around Natural Bridge and Kingshighway. She has told them to call the police. The resident has a guardian. He/She is oriented. He/She has mental illness and poor decision making.

As of 1/5/24, Resident #9's whereabouts are unknown.

4. Record review of an email dated 12/16/23 at 1:17 PM, showed DHSS administration emailed CFO, Owner B's chief financial officer, and the registered agent for Northview Village, Inc, advising of resident medical information needed, concerns regarding residents relocated to Facility B and Facility C and the payroll status at those facilities and a second request for immediate contact. No response was received on 12/16/23.

During an interview on 12/17/23 at 1:22 PM, CFO and Owner A, CFO stated Northview Village has been losing money for years and Owner A has been funding losses. Two financial backers, including Owner C, were asked to help cover the payroll, however, they did not do so. The facility would receive their Medicaid reimbursement check that week and they should be able to pay employees. Most of the facility's 170+ residents were Medicaid recipients.

During an interview on 12/21/23 at 10:56 A.M., the DON said staff were supposed to be paid on 12/22/23. They will be paid for vacation time and the following week next week. She still has had

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F 835	Continued From page 58 no response from the owners. They had staffing problems and she told him recently they had to use agency. They should have done this decently and in order. MO00229176 MO00228843 MO00228849 MO00228917 MO00228927 MO00228991 MO00229053 MO00229075 MO00229105	F 835		

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A4003	19 CSR 30-85.042(3) Operator/Administrator Responsibilities The operator shall be responsible to assure compliance with all applicable laws and rules. The administrator shall be fully authorized and empowered to make decisions regarding the operation of the facility and shall be held responsible for the actions of all employees. The administrator ' s responsibilities shall include the oversight of residents to assure that they receive appropriate nursing and medical care. II/III This regulation is not met as evidenced by: Class II* See the deficiency cited at F835. *The higher classification is merited due to the extent of the violation and its effect on the residents.	A4003		
A4016	19 CSR 30-85.042(16) No Adverse Effect-Res Health/Safety/Property All persons who have any contact with the residents in the facility shall not knowingly act or omit any duty in a manner which would materially and adversely affect the health, safety, welfare or property of a resident. I This regulation is not met as evidenced by: See the deficiencies cited at F835 and E20.	A4016		
A4074	19 CSR 30-85.042(65) Protective Oversight, Voluntary Leave Each resident shall receive twenty-four- (24-) hour protective oversight and supervision. For residents departing the premises on voluntary	A4074		

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A4074	Continued From page 1 leave, the facility shall have, at a minimum, a procedure to inquire of the resident or resident's guardian of the resident's departure, of the resident's estimated length of absence from the facility, and of the resident's whereabouts while on voluntary leave. I/II This regulation is not met as evidenced by: Class I* See the deficiency cited at F689. *The higher classification is merited due to the extent of the violation and its effect on the residents.	A4074		