Health Facilities Commission

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53748	A. BUILDING: _____ B. WING _____	R 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKING HORSE MEADOWS	207 UFFELMAN DRIVE CLARKSVILLE, TN 37043

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 001}	0720-26 Initial Comments This Rule is not met as evidenced by: A revisit was conducted on 1/7/2026 at Walking Horse Meadows. Deficiencies were cited for D720 and D721 related to an elopement on 1/6/2026. Deficiencies D608, D1223 and D1301 were cleared under Chapter 0720-26, Standards for Assisted Care Living Facilities.	{D 001}	**D720- Safety** **The community took immediate and ongoing actions to address the safety and behavioral needs of Resident #11.** • **On 1/6/2026, Resident #11's care plan was updated to address behavioral concerns and safety risks.** • **On 1/6/2026, the resident was added to behavior monitoring in the care tracking system. Addendum-What does the behavior monitoring include? Who does the monitoring, how often is this documented, what exactly is monitored, etc.? Behavior monitoring includes observation and documentation of the resident's mood, affect, behavioral expressions, exit-seeking behaviors, agitation, refusal of care, and any environmental triggers. Monitoring is conducted by the direct care staff on each shift. Behavior monitoring is documented every shift on the resident's electronic health record. Staff record the behavior observed, precipitating factors, interventions attempted, and resident response. The nursing supervisor reviews this documentation daily.** • **On 1/6/2026, safety checks were increased to four (4) times per shift to ensure resident safety and close supervision. Addendum-The safety checks 4 times per shift-is it an 8 hour or 12-hour shift? Who is responsible for conducting the safety checks? What does close supervision mean? Are these checks different than the two-hour checks memory care residents were placed on? Is resident #11 on 2-hour safety checks or safety checks 4 times per shift? Safety checks four times per shift occur during an 8-hour shift. These checks are completed by the direct care staff**	1/15/2026
{D 720}	0720-26-.07 (7)(a)(2) Services Provided (7) An ACLF shall provide personal services as follows: (a) Each ACLF shall provide each resident with at least the following personal services: 2. Safety when in the ACLF This Rule is not met as evidenced by: Based on policy review, facility document review, medical record review and interview, the facility failed to provide safety for 1 of 3 (Resident #11) residents reviewed for elopement. The findings included: 1. Review of the facility policy "Elopement Prevention" revised 4/17/2024, revealed, "Upon move in each resident will be evaluated for potential for elopement and noted on their service plan. If resident has potential for elopement...related interventions...added to service plan...discuss possibility of elopement with family...environmental safeguards...keyed entry/egress...alarmed outside windows...preventive maintenance in place...proper functioning of system...families	{D 720}		

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{D 720}	Continued From page 1 educated regarding system safeguards upon move-in...signage placed as necessary..." 2. Review of the medical record revealed Resident #11 was admitted to the facility on 9/23/2025 with diagnoses including Alzheimer's Disease. Review of the Individual Service Plan (Care Plan) dated 9/23/2025, revealed Resident #11 was planned for wandering behaviors with staff to monitor and redirect as needed. The Resident was ambulatory with a wheelchair. Review of the Individual Service Plan dated 10/30/2025, revealed Resident #11 was planned for wandering/elopement with interventions for supervision/oversight during periods of wandering to ensure safety. 3. Review of the Incident Reporting Form dated 1/6/2026, revealed Caregiver #1, #2, and #3 reported Resident #11 was found on the front porch of the building at approximately midnight (1/5/2026). The Resident had been exit seeking most of 3rd shift, and she was agitated and very "busy" around the unit. The Caregivers realized they had not seen or heard her in approximately 15 minutes, so they went looking for her. During their search, they found the double doors that led to assisted living dining room had been opened despite being locked. They found the Resident had gone through a side door which led from the dining room to the front porch of the building where she was found seated in a chair with a new bruise under her chin. The Resident reported she was grateful to be brought back inside because she was cold. Review of the Investigation Statement Form	{D 720}	**assigned to the resident. "Close supervision" means staff visually confirming the resident's location and ensuring they are safe, not exhibiting exit-seeking behaviors, and engaging appropriately in their environment.** **The four-times-per-shift safety checks are separate from and in addition to the standard two-hour personal care rounds performed in memory care.** **Resident #11 is currently on safety checks four times per shift, and this intervention is documented on the resident's care plan.** • **Multiple medication adjustments were initiated to address behaviors:** o **1/5/2026: Depakote 125 mg increased to three (3) tablets three times daily (TID). Addendum-When was the Depakote 125 mg increased to three tablets TID? The increase was made on 1/5/2026.** o **1/6/2026: Nurse Practitioner reviewed the medication list and ordered Seroquel 25 mg, one-half tablet twice daily (BID).** o **1/8/2026: Nurse Practitioner reviewed the medication list again and discontinued Buspar, continuing all other medications as ordered.** o **1/15/2026: Seroquel increased to 25 mg three times daily (TID) and Trazodone adjusted to 50 mg at bedtime (QHS).**	1/15/2026

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{D 720}	Continued From page 2 dated 1/6/2026, revealed, Caregiver #1 documented she was doing rounds and heard Caregiver #2 and #3 outside the main door of the facility. Resident #11 was on the ground on her bottom dressed in her nightgown. Caregiver #1 documented that she and Caregiver #3 went into the dining room to see how Resident #11 got out and noticed that the door to the assisted living dining room was not locked. Review of the Investigation Statement Form dated 1/6/2026, revealed Caregiver #2 documented that Resident #11 was up walking the halls, and when she checked Resident #11's room, the Resident was not there. The doors that led to the assisted living dining room were open. Caregiver #2 saw the Resident seated in a chair on the front porch tapping on the main door. The Caregivers assisted her back to her room and noticed the Resident had some discoloration on her chin. Review of the Investigation Statement Form dated 1/6/2026, revealed Caregiver #3 documented that she was doing rounds, and when she entered Resident #11's room, she noticed Resident #11 was not in her bed. Caregiver #3 documented she saw the Resident walking earlier and redirected her back into her room for bed. The Resident reported she was waiting for her husband and mother. Caregiver #3 documented that the Caregivers started looking for Resident #11 and saw the door to kitchen had been left open. Caregiver #3 went into the kitchen and saw the kitchen door open and realized that the Resident went out the kitchen door to the front porch. 4. During an interview on 1/7/2026 at 10:00 AM, the Health and Wellness Director (HWD) stated	{D 720}	**D720** To help prevent the recurrence with other residents the Health and Wellness Director or designee to add individualized interventions for any resident exhibiting increased confusion or exit seeking. All Memory care residents are placed on 2-hour checks in the community's care tracking system for the team to confirm whereabouts. **Addendum-How will you monitor the HWD/designee to ensure individualized interventions are developed and implemented when a resident shows increased confusion or exit-seeking?** The Administrator will perform a weekly audit of any resident(s) identified with increased confusion, behavioral changes, or exit-seeking behaviors. The audit will confirm that: • A behavior assessment has been completed • Individualized interventions have been care-planned Results will be presented to QAPI for oversight quarterly. And maintained in the Administrator's office. The next scheduled QAPI is 4/3/2026. The parties included in the QAPI are the Administrator, Health and Wellness Director, Business Office Manager, Environmental Services Director, Life Enrichment Director, Director of Sales and Marketing, Memory Care Director and Dining Services Director.	1/15/2026

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{D 720}	Continued From page 3 Resident #11 eloped through the double doors that went into the assisted living dining room. The HWD stated that the doors were locked and had curtains over them, but if someone shook the doors and pushed on them, they would open. The HWD stated the Resident went through the dining room to a side door and exited the building. The HWD stated someone could go out that door but could not come back in it because it would lock. The HWD stated the Resident was found by staff outside the building knocking on the front door. During a telephone interview on 1/7/2026 at 2:52 PM, Caregiver #1stated she heard noises from the front door and went to the door. Caregiver #1 stated that she saw Caregiver #2 and #3 helping Resident #11 up and back into the facility. Caregiver #1 stated she in the dining room and found the door to the dining room was not locked. Caregiver #1 stated that she noticed Resident #11 had a bruise on her chin after she was assisted back inside the building. During a telephone interview on 1/7/2026 at 2:58 PM, Caregiver #2 stated Resident #11 had been up all-night wandering, and when she attempted to assist Resident #11 back to bed, the Resident would not go. Caregiver #2 stated that when the Caregivers were doing their rounds, they noticed that Resident #11 was not in her room. They searched for the Resident and found her sitting on her bottom outside the building by the front door. Caregiver #2 stated that the Resident had a bruise on her chin.	{D 720}	**D720** The Environmental Services Director performs checks on all egress doors, locks and alarms weekly through Direct Supply TELS platform. Proper signage is place on exit doors "Alarms will sound". **Addendum- Environmental Services weekly checks on egress doors, locks, and alarms — how will this be documented?** **Environmental Services will document weekly egress door, lock, and alarm checks on through Direct TELS log. The log includes:** • **Date of inspection** • **Name of staff completing the check** • **Functionality status of alarms, locks, and magnetic hardware (Pass or Fail) notation of failure can be added to the log should the equipment fail.** • **The Environmental Services Director will report any deficiencies identified to the Administrator during weekly checks.**	1/15/2026
{D 721}	0720-26-.07 (7)(a)(3) Services Provided (7) An ACLF shall provide personal services as follows:	{D 721}		

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{D 721}	Continued From page 4 (a) Each ACLF shall provide each resident with at least the following personal services: 3. Daily awareness of the individual ' s whereabouts This Rule is not met as evidenced by: Based on policy review, facility document review, medical record review and interview, the facility failed to maintain a daily awareness of a resident's whereabouts for 1 of 3 (Resident #11) residents reviewed for elopement. The findings included: 1. Review of the facility policy "Elopement Prevention" revised 4/17/2024, revealed, "Upon move in each resident will be evaluated for potential for elopement and noted on their service plan. If resident has potential for elopement...related interventions...added to service plan...discuss possibility of elopement with family...environmental safeguards...keyed entry/egress...alarmed outside windows...preventive maintenance in place...proper functioning of system...families educated regarding system safeguards upon move-in...signage placed as necessary..." 2. Review of the medical record revealed Resident #11 was admitted to the facility on 9/23/2025 with diagnoses including Alzheimer's Disease. Review of the Individual Service Plan dated 10/30/2025, revealed Resident #11 was planned for wandering/elopement with interventions for supervision/oversight during periods of wandering to ensure safety.	{D 721}	**D721- The community took immediate and ongoing actions to address the safety and behavioral needs of Resident #11.** **• On 1/6/2026, Resident #11's care plan was updated to address behavioral concerns and safety risks.** **• On 1/6/2026, the resident was added to behavior monitoring in the care tracking system. Behavior monitoring includes observation and documentation of the resident's mood, affect, behavioral expressions, exit-seeking behaviors, agitation, refusal of care, and any environmental triggers. Monitoring is conducted by the direct care staff on each shift. Behavior monitoring is documented every shift on the resident's electronic health record. Staff record the behavior observed, precipitating factors, interventions attempted, and resident response. The nursing supervisor reviews this documentation daily.** **• On 1/6/2026, safety checks were increased to four (4) times per shift to ensure resident safety and close supervision. Safety checks four times per shift occur during an 8-hour shift. These checks are completed by the direct care staff assigned to the resident. "Close supervision" means staff visually confirming the resident's location and ensuring they are safe, not exhibiting exit-seeking behaviors, and engaging**	1/15/2026

			appropriately in their environment. **The four-times-per-shift safety checks are separate from and in addition to the standard two-hour rounds performed in memory care.** **Resident #11 is currently on safety checks four times per shift, and this intervention is documented on the resident's care plan.**	
			D721 Continued. **On 1/9/2026, Environmental safety improvements were addressed by installing proper locking mechanism on the door that the resident went out of.** **• Increased monitoring and documentation of behaviors and safety checks are incorporated into daily operations and reviewed by leadership.** **Monitoring and Compliance** **• Compliance is monitored through weekly collaborative care reviews, behavior monitoring logs, medication reviews, and safety checks.** **• The Administrator or designee will ensure continued compliance through the facility's Quality Assurance process quarterly. The parties included in the QAPI are the Administrator, Health and Wellness Director, Business Office Manager, Environmental Services Director, Life Enrichment Director, Director of Sales and Marketing, Memory Care Director and Dining Services Director**	

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{D 721}	Continued From page 5 3. Review of the Incident Reporting Form dated 1/6/2026, revealed Caregiver #1, #2, and #3 reported Resident #11 was found on the front porch of the building at approximately midnight (1/5/2026). The Resident had been exit seeking most of 3rd shift, and she was agitated and very "busy" around the unit. The Caregivers realized they had not seen or heard her in approximately 15 minutes, so they went looking for her. During their search, they found the double doors that led to assisted living dining room had been opened despite being locked. They found the Resident had gone through a side door which led from the dining room to the front porch of the building where she was found seated in a chair with a new bruise under her chin. The Resident reported she was grateful to be brought back inside because she was cold. Review of the Investigation Statement Form dated 1/6/2026, revealed, Caregiver #1 documented she was doing rounds and heard Caregiver #2 and #3 outside the main door of the facility. Resident #11 was on the ground on her bottom dressed in her nightgown. Caregiver #1 documented that she and Caregiver #3 went into the dining room to see how Resident #11 got out and noticed that the door to the assisted living dining room was not locked. Review of the Investigation Statement Form dated 1/6/2026, revealed Caregiver #2 documented that Resident #11 was up walking the halls, and when she checked Resident #11's room, the Resident was not there. The doors that led to the assisted living dining room were open. Caregiver #2 saw the Resident seated in a chair on the front porch tapping on the main door. The Caregivers assisted her back to her room and	{D 721}	

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{D 721}	Continued From page 6 noticed the Resident had some discoloration on her chin. Review of the Investigation Statement Form dated 1/6/2026, revealed Caregiver #3 documented that she was doing rounds, and when she entered Resident #11's room, she noticed Resident #11 was not in her bed. Caregiver #3 documented she saw the Resident walking earlier and redirected her back into her room for bed. The Resident reported she was waiting for her husband and mother. Caregiver #3 documented that the Caregivers started looking for Resident #11 and saw the door to kitchen had been left open. Caregiver #3 went into the kitchen and saw the kitchen door open and realized that the Resident went out the kitchen door to the front porch. 4. During an interview on 1/7/2026 at 10:00 AM, the Health and Wellness Director (HWD) stated Resident #11 eloped through the double doors that went into the assisted living dining room. The HWD stated the Resident was found by staff outside the building knocking on the front door.	{D 721}		