Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008130	A. BUILDING: ______ B. WING ______	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS AT ROCK ISLAND	2545 24TH STREET ROCK ISLAND, IL 61201

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S 000	Initial Comments Facility Reported Investigation (FRI) to Incident of 10-23-21/IL00139814 Complaint Investigation: #2128138/ IL00139876 Complaint Investigation: #2128162/ IL00139909	S 000		
S9999	Final Observations Statement of Licensure Violations: (1 of 2) 300.610a) 300.1210b) Section 300.610 Resident Care Policies a)The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b)The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with	S9999		

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each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

These Requirements were not met evidencded by:
Noncompliance resulted in two deficient practice statements.

A. Based on interview, and record review, the facility failed to protect a resident (R1) in the locked Dementia Unit from an oriented, ambulatory resident (R2),who displayed increasing, escalating behaviors, for one of five residents (R1) reviewed for abuse, in a sample of 17. This failure resulted in R2 physically abusing R1 by throwing R1 to the ground resulting in R1 crying and being visibly upset.
B. Based on record review, and interview, the facility failed to protect a resident from verbal abuse for one of five residents (R5) reviewed for abuse in the sample of 17.

A. FINDINGS INCLUDE:

R2's facility Referral Packet, dated 10/28/2021 and addressed to V9/Marketing Liaison documents R2's diagnoses as Schizoaffective Disorder, Depression and Chronic Obstructive Pulmonary Disease. This same packet included R2's current Care Plan with the following problems: I have a history of substance abuse, severe and alcohol abuse, moderate related to depression and anger.

R2' facility Face Sheet documents that R2 was admitted to the facility on 10/29/2021 to the

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S9999	Continued From page 2 Fourth floor, Room 404-3 with the following diagnoses: Schizophrenia. R2's Nursing Progress Notes, dated 10/29/2021 at 4:48 P.M. and signed by V13/Nurse Practitioner document, "(R2) is a 58 year old resident who transferred from (sister facility) today. (R2's) medical history is significant for COPD (Chronic Obstructive Pulmonary Disease) Stage IV, nicotine dependence, and Schizoaffective disorder. Admission notes indicate extremely non compliant behavior especially with smoking. (R2) likely needs supplemental oxygen 24/7 (around the clock) at 2-3 (liters) but has already refused to wear it consistently. (R2) has psychiatric illness requiring assistance with daily cares. (R2) is irritated and was difficult to assess upon admission due to aggressive behavior. (R2) kicked out at (V10/Admission Licensed Practical Nurse) at one point. Physical assessment was completed the best I could. I thanked (R2) for allowing me to assess (R2) and (R2) said "F ... you". (R2) is clearly extremely sob (short of breath) even at rest due to the severity of (R2's) COPD. (R2) appears to only put the oxygen on when (R2) wants to. (R2) has already asked to go out to smoke. (R2) is not answering questions appropriately due to how irritated (R2) is. (R2) told (V10/Admission Licensed Practical Nurse) to "get the f ... away from me" more than once." R2's Nursing Progress Notes, dated 10/29/2021 at 8:28 P.M. document, "While moving the new resident (R9), who was scared to remain in the same room with (R2) stating (R2) is "a f...ing psycho", (R2) attempted to grab or swing out at (V10/Admission Licensed Practical Nurse) while (V10's) back was facing (R2) while talking to (R9). Myself (V13) and two other CNAs (Certified	S9999		

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Nursing Assistants) verbally shouted at (R2) to "STOP!!" to dissuade (R2) from attempting to make physical contact. (R2) sat back down on the bed abruptly after our verbal outcry. (R2) was offered anxiety medication to see if this would decrease some of (R2's) agitation but (R2) vehemently refuses. Message left on (V1/Administrator) phone about the incidents with (R2) regarding aggression towards V10/LPN) and (R1)."

R2's Nursing Progress Notes, dated 10/29/2021 at 9:04 P.M., by V10/Admission Licensed Practical Nurse document, "Admission Note, Admitted from: Long term care (sister facility). Cognition (Oriented to): Person, alert. Upon arrival (R2) was combative kicking at me. R2's clothes are dirty, (R2) refuse to let staff change him. (R2) is incontinent of urine and BM (stool). Open area on buttock (R2) refuse to let staff assess, measure, or clean the area. (R2) continue to refuse assistance and (R2) refuse medications as well calling staff bi...chs hitting at staff. (R2's) roommate (R9) was transferred to another room (R9) was scarred of (R2). Notified (V2) DON (Director of Nurses) and left message for (V1)Administrator."

R1's Nursing progress Notes, dated 10/29/2021 at 8:15 P.M. by V13/Nurse Practitioner document, "V10/Licensed Practical Nurse called me to report (R1) had been thrown to the floor by (R2). CNAs report they saw (R2) grab (R1) by the arm and throw (R1) down to the ground. It was reported (R1) was crying and visibly shaking. (R1) does wander but has been very pleasantly confused without issues of aggression. (R2) has been verbally aggressive and attempted to kick at (V10/LPN) earlier during my initial physical assessment. (R1) is resting in bed comfortably

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and does not remember the incident. No bruising or signs of pain, swelling, or injury. Diagnosis/Plan: Physical Abuse/Altercation: No signs of swelling, redness, or bruising. The nurse will pass on to first shift to monitor (R1) for limping, bruising, or swelling to the hips or any extremities. No further orders at this time. CNAs noted to watch closely to ensure (R1) does not wander into (R2's) room again."

On 11/3/2021 at 8:50 A.M., V11/Certified Nursing Assistant (CNA) stated, "I was working the afternoon that (R2) was admitted. (R2) was verbally and physically abusive from the time (R2) got here. At one point, I was out in the hallway taking care of another resident and I saw (R1) go into (R2's) and heard (R1) yelling. I saw (R2) grab (R1) by the arm and throw (R1) to the ground. I ran and got the nurse to check (R1) for injuries."

On 11/3/2021 at 9:03 A.M., V10/Licensed Practical Nurse stated, "I was the nurse on duty the day (R2) was admitted. I'm not sure why (R2) was admitted to the locked unit, (R2) didn't have a Dementia diagnosis. (R2's) diagnosis is Schizophrenia. (R2) is alert, and oriented. From the time (R2) got here he was verbally abusive to staff and other residents. (R2) was combative, trying to hit and kick me. I had to move (R2's) roommate (R9) because (R9) was afraid to stay in the same room as (R2). I was out of the unit charting at the nurse's station when (V11)/Certified Nursing Assistant (CNA) came and got me to tell me that (R1) had wandered into (R2's) room and (R2) had grabbed (R1) by the arm, and threw (R1) to the ground. (R1) didn't have any visible injuries, but (R1) was visibly shaken and crying."

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On 11/4/2021 at 10:12 A.M., V8/Admissions Coordinator stated, "I wasn't the one who made the decision to place (R2) in the Dementia unit when (R2) was admitted. (V9/Marketing Director) made that decision. She said (R2) is an elopement risk, so V9 wanted (R2) in the locked unit. Usually a resident has to have a diagnosis of Dementia to be admitted to that unit. We received a referral for (R2) because (R2) requires oxygen now. (V9/Marketing Director) last day of employment is today. (V9) no longer works for our company."

On 11/4/2021 at 1:35 P.M., V1/Administrator stated, "Admission to our locked Dementia unit is dependent on a diagnosis of Dementia. When I found out the next day that (R2) was admitted to the unit with only a diagnosis of Schizophrenia, I was very upset. (V9/Marketing Director) made the call to admit him there without my approval."

B.

FINDINGS INCLUDE:

On 11/9/21 at 10:30 am, R5 was asked about the incident that occurred with R6 and V23 (R6's family). R5 started crying and stated, "That was the worst day of my life! I got a new roommate (R6) who was very large and has a big wheelchair as well as lots of stuff. I wheeled my wheel chair to my bed and I got tangled with (R6's) wheelchair. I asked (R6) to help me by moving her wheel chair and she wouldn't say anything she just glared at me. (R6) had boxes and stuff everywhere in our room. I couldn't get around and they were moving all my stuff in my closet. I asked (V23) to not touch my stuff. I understand she needed a side of the closet, but she didn't

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need to touch my stuff. At one point, (V23) came thru the door mad. (V23) threw her arms up and said, "You're a b..ch." So, I said back to her well you're a b...h too.
I knew I didn't do anything, and I thought oh my god I couldn't live like this. All I could think was is this my punishment, a roommate I can't get along with. I was crying when this all happened. I was pretty upset."

On 11/9/21 at 11:00 a.m., V4 (CNA-Certified Nursing Assistant) stated, "I was working the day (11/2/21) of the argument (between R5 and R6 and V23). I was sitting here at the nurses' desk charting. All I could hear was arguing and someone yelling, 'Give us a break. It's our first day here.' I went down to their room to see what was going on. When I got into the room, (R5) was crying, (R6) was crying, and (V23) was red faced and angry. I wondered why the residents were crying. I asked (R5) if she was ok, and (R5) said, 'That lady (V23) called me a b...ch.' Right away, (V23) said, 'Yeah, I was the one who called (R5) a b...tch because she called me a b...ch.' It was out of control and (V23) was out of control. These residents are completely with it. (V23's) a grown woman she shouldn't be arguing with any of the residents. I wouldn't want anyone talking to any of my family members that way. (V23) was verbally abusive to (R5), and (V23) was crazy you don't yell at a resident like that."

The (undated) facility policy, Abuse Prevention Program directs staff, "This facility prohibits mistreatment, neglect, exploitation, misappropriation of resident property, or abuse of it's residents. This facility is committed to protecting our residents from abuse by anyone, including, other residents."

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The facility's Abuse Prevention Program Facility Policy documents, "This facility prohibits mistreatment, neglect, exploitation, misappropriation of resident property, or abuse of its resident." The policy also documents, "Verbal abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm, saying things to frighten a resident

" B "

(2 of 2)
Statement of Licensure Violations:

300.610a)
300.1210b)
300.1210d)6)

Section 300.610 Resident Care Policies

a)The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The

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policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

b)The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.
d)Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
6)All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents

These Requirements were not met evidenced by:

Noncompliance resulted in two deficient practice statements

A. Based on interview, and record review, the facility failed to follow recommended transfer assistance during a transfer for one of three residents (R3), reviewed for falls, in a sample of

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17. This failure resulted in R3 being improperly transferred and sustaining a fall which resulted in sustaining multiple fractures.

B. Based on observation, interview, and record review, the facility failed to provide supervision to prevent a resident from exiting the facility unattended and have a properly functioning elopement monitoring system for six of six residents (R1, R5, R11-R13, R15) reviewed for elopement risk in the sample of 17.

A. FINDINGS INCLUDE:

The facility policy, Mechanical Lift, dated (revised) 02/2017 directs staff, "A (mechanical) lift assists staff to lift and move a resident as safely and as easily as possible. A (mechanical) lift should be used for heavy residents or for those who are disabled. Two staff members are required for the procedure."

The Mechanical Lift manufacturer's guide documents, " allow's patients up to 400 and 500 pounds, respectively, to be lifted and transferred safely with minimal physical effort provided by the operator. That is due to it being a full electrical lift. Mechanical lift can lift the patient with ease from the floor to the bed. The six point spreader bar provides added comfort for the patient while moving from any surface. Battery: If the battery is critically low, the LCD (Liquid Crystal Display) Display Panel will show, Charge Battery Immediately. Lift operation is deactivated. Battery needs to be charged immediately before further use."

The Battery Powered Patient Lift manufacturer's guide documents, "(The manufacturer)

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S9999	Continued From page 10 recommends the battery be recharged daily to prolong battery life. A battery needing to be fully charged will take approximately four hours." R3's facility Resident Face Sheet documents that R3 was admitted to the facility on 1/5/2017 with the following diagnoses: Chronic Respiratory Failure, Chronic Obstructive Pulmonary Disease, Hypertensive Heart and Chronic Kidney Disease, Diabetes Mellitus, Primary Generalized Arthritis, Fibromyalgia, Bicipital Tendinitis, Muscle Weakness and Morbid Obesity. R3's current (undated) Care Plan includes the following Problem area: (R3) has (an) inability to transfer self related to weakness. (R3) is a (mechanical lift) for transfers. The following approaches include: Use two staff to transfer (R3). R3's current Minimum Data Set Assessment, dated 10/08/2021 documents: Cognition- 11:15 (cognitively intact); Functional Status, transfers-total dependence on two staff members. R3's PT (Physical Therapy) Discharge Summary, dated 10/15/2021 documents, "Discharge Recommendations: Recommending discharge to this facility at a wheel chair level, continue (mechanical lift) with staff for safety. Lateral scoot transfer with board, moderate assist of two for safety." R3's electronic Nursing Progress Notes, dated 10/23/2021 at 8:58 P.M. and signed by V6/Registered Nurse (RN) document, "(R3) had been up in wc (wheel chair) since early afternoon. CNAs (Certified Nursing Assistants) stated (mechanical lift) battery not charging, (V6/RN) did assess (mechanical lift) and charging light not	S9999		

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coming on. Unable to leave (R3) in wc all night, (V6/RN) called for a non-emergency transfer from wc to bed. EMTs (Emergency Medical Transports) arrived in (R3's) room with (V6/RN) and four other staff members. Gait belt was placed for safety. On count of three, staff used gait belt to lift resident from wheel chair. EMTs were to grab backside of (R3) to assist with transfer. (R3's) legs buckled prior to EMTs getting ahold of (R3). (R3) landed on knees and left and right feet buckled inward and backward. (R3) complained of pain to right foot. (R3) unable to rate pain at that time. (V6/RN) applied ice to (R3's) right lateral foot. Staff aware to continue to assess for swelling, bruising or increased pain."

R3's Nursing Progress Notes, dated 10/24/2021 at 8:01 A.M. document, "(R3) was yelling out in pain this AM (morning). Complains of right foot pain and lower back pain." At 9:10 A.M. (R3's) notes document, "(R3) sent out to ER (Emergency Room)."

R3's Nursing Progress Notes, dated 10/24/2021 at 12:37 P.M. document, "ER (Emergency Room) Nurse called back and stated that (R3) will be returning within the hour. (R3) had a right ankle FX (fracture) and a left fibula fracture. Follow up with(Local Orthopedic Group) on Monday."

R3's ED (Emergency Department) Provider Notes, dated 10/24/2021 document, "(R3) presents with fall overnight. (R3) is obese, requiring a (mechanical lift). (R3) reports to me that the (mechanical lift) was malfunctioning at the (facility) and nurses attempted to transfer (R3) form the chair to the bed using a walker and assist of two. (R3) states that as she stood up, her feet went backwards underneath her and she fell onto her right side. (R3) states she did not

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S9999	Continued From page 12 strike her head. Diagnoses: Right ankle fracture and Closed fracture of proximal end of left fibula." On 11/3/2021 at 2:12 P.M., V6/Registered Nurse (RN) stated, "I was here on 10/23/2021 around 8:00 P.M. when the accident with (R3) occurred. The CNAs had tried the lifts and neither of them would work. The battery was dead, it wouldn't run. I called for lift assistance from the ambulance service. I put a gait belt on (R3). When we tried to stand her, she went to her knees and yelled that her leg hurt. We did not go get the lift from the fourth floor. We did not attempt a slide board transfer before we tried to stand (R3)." On 11/3/2021 at 3:10 P.M., V7/Maintenance Director stated, "The (mechanical lifts) are supposed to be plugged in between use to recharge the batteries. There are two docking stations on the second floor, near the nurse's station and and clean utility room. When I looked at the lift, the fuse in the battery pack was blown. I had to replace it. It wouldn't hold a charge." On 11/4/2021 at 8:17 A.M., V5/Certified Nursing Assistant stated, "(On 10/23/21), The lifts wouldn't work. The battery was dead. We had eight people to help lift (R3). But (R3) got weak and began to fall. We didn't try a slide board transfer on (R3). Nobody went to and got the lift from the fourth floor to try." On 11/4/2021 at 8:37 A.M., V3/Certified Nursing Assistant stated, "I was working on the fourth floor and we got a call that they (second floor) needed help transferring (R3). Nobody asked us to bring our lift. We attempted to stand (R3) and she got weak and fell. Nobody attempted a slide board transfer."	S9999		

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On 11/4/2021 at 8:42 A.M., V4/Certified Nursing Assistant stated, "We tried to transfer (R3) from her wheel chair to the bed. She stood, but got weak and fell to her knees."

On 11/4/2021 at 8:29 A.M., V24/Physical Therapist stated, "(R3) hasn't stood to transfer for many years. She doesn't have the strength for that. (R3) was in Physical Therapy from 8/31/2021 until I discharged her on 10/15/2021. She was discharged at a transfer with a mechanical lift or a two person lateral scoot, using a slide board."

R3's Progress Notes, dated 11/8/2021 by V25/Physician's Assistant document, "(R3) presents to the clinic for evaluation of a bilateral leg pain. (R3) was attempting to transfer from her wheel chair to bed, when her legs buckled underneath her and she rolled her ankles. Pain is currently described as aching, throbbing and occasionally sharp. Pain is rated at 10:10 in severity, at it's worst. Radiology: views of the right foot, right ankle, left tibia/fibula and left foot were obtained. Assessment: Closed, nondisplaced right second metatarsal base fracture; closed, nondisplaced right second middle phalanx fracture; right ankle sprain with chronic appearing distal fibula fracture; left ankle sprain; chronic left proximal fibula fracture and diffuse disuse osteopenia. Plan: (R3) was placed into a right short-leg fiberglass cast and a pneumatic boot on the left. (R3) is currently non-weight bearing and utilizes a (mechanical lift) for transfers."

B. Findings include:

The facility's Elopement Risks policy, dated 5/2017, documents, "Objective: To keep residents at risk for wandering safe from this behavior and

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S9999	Continued From page 14 thus risks associated with wandering. For those residents who are assessed as potential risk for, or known history of, or observed to wander: Are monitored frequently; All exits are alarmed or in visual control 24 hours a day." The facility's Wander Management policy, dated 2016, documents, "How it works: Each resident wears a small radio transmitter and exits are protected by door controllers. When a resident approaches an exit, the door controller locks the door to prevent the resident from leaving; if the door is opened, an alarm sounds." The facility's Elopement tag User Guide, dated 8/2017, documents, "Monthly testing and maintenance of this product is essential to verify the system is operating correctly and to ensure that the probability of detecting an alarm and/or locating the transmitter are maximized. The failure to undertake regular testing and maintenance will increase the risk of system failure and failure to detect resident wandering. The failure to undertake regular testing and maintenance will increases the risk of false reports of resident wandering." Awritten summary signed by V1 (Administrator) documents, "Upon further investigation, it was found that the service elevator had malfunctioned. The button on the elevator was broken and was getting called to the fourth floor. R5 stated that no one was at the nurses desk and she wanted to go outside so she walked onto the service elevator and then walked out." On 11/9/21 at 10:30 a.m., R5 stated, "I wear an elopement device (pointing to her right ankle where a device with strap was attached to her ankle) so that I don't leave the building. The staff	S9999		

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are supposed to take us out to smoke after our meals. We only go out three times a day. Last Sunday (10/31/21), they kept telling me they didn't have time to take us out to smoke, and we weren't going to go out. So, when the elevator door was open and no one was around. I got on, and no one stopped me from going downstairs. I got off the elevator on the first floor turned right. Went through the double doors towards the laundry room. Then, I went thru another door that goes back to laundry. The exit door is right beside laundry, and it was propped open. With it being propped open I knew the alarm wouldn't go off. So, I thought to myself, 'hey why not get some fresh air, and maybe someone is out there smoking that I could bum a cigarette from.' That is where staff go to smoke. So, with my good leg, I kicked the door open and wheeled myself out onto the sidewalk. No one was out there, but I thought I'm free! I stayed on the sidewalk and just absorbed the fresh air. A doctor from next door eventually came over to me and asked if I was a resident. I told him yes and he brought me around to the front door where two CNAs (Certified Nursing Assistant) came down to get me and take me back up to the fourth floor."

On 11/9/21 at 2:00 p.m., an exit door was located next to the laundry room. When opened the door alarmed. However, the door required to be pulled shut in order to reactivate the system.

R5's Care plan, dated 7/22/21, documents, "I (R5) wander at times. I have an elopement device in place." The care plan also documents the following interventions: Equip resident with a device that alarms when wanders. Check for placement of device as ordered.

On 11/8/21 at 2:00 pm, V2 (Director of Nursing)

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stated, "For some reason, (R5's) elopement device did not trigger the door lock when she went out the door. We think (R5) went out the front door. The elevator was malfunctioning and the door was opening randomly. So she didn't need the code to get onto the elevator. Her elopement device didn't work properly either. I'm not sure of who checks the functioning of the elopement device. I took the elopement device and checked it on the back door. It alarmed but did not lock. The front door did not alarm or lock when I tried it."

A facility elevator service visit form, dated 10/31/21, documents, "V7 (Maintenance Director) called on 10/31/21 at 10:51 a.m. reporting #2 East Kitchen elevator was shut down. When we arrived at 11:18 a.m. the unit was running with a door operation problem. We replaced the car pushbutton switch; replaced the car pushbutton contact; adjusted the car station wiring, and adjusted the car pushbutton contact."

On 11/10/21 at 11:15 a.m., V13 (Registered Nurse) stated, "Last time I saw (R5) was before 9:00 a.m. when I passed her medications. That morning, (R5) was yelling about going out to smoke. Then, I get a phone call that (R5) was outside the building. I was told she was found in a smoking area. There wasn't any alarms going off. The elopement device was on her ankle but nothing sounded."

On 11/9/21 at 9:00 am, V7 (Maintenance Director) stated, "My responsibility is to do a monthly test on the elopement devices by taking a resident to the front door or the resident smoking door and seeing if the alarm goes off. If it doesn't then we have an issue. I don't check their alarms on the laundry room exit door

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because the residents don't use that door. If a elopement device is near the exit, it will immediately lock the door and start beeping at the keypad. The front door was not signaling quick enough in response to what the nurses were telling me. I don't know what the manufacturers guidelines are to check the device and our wander system. I check the exit doors randomly throughout the week to make sure they are sounding, but I don't have any kind of log. The elopement device that was on (R5) when I checked it didn't lock the door immediately, like it is supposed to do when she approaches the door. The alarm then sounded. The nurses working stated the alarm did not even go off. I did not have anyone look into the elopement system. The elevator buttons are plunger so when the button is pushed it should plunge back out and this one did not. So no matter what if I was on 2nd floor it would take me to the first floor but then automatically take me up to the fourth floor. It was reading as if someone was pushing the button to get onto the fourth floor. So ultimately with the elevator door malfunctioning she was able to get onto the elevator, which she shouldn't have been able to, and then the wander guard system malfunctioned as well allowing her to get outside."

On 11/10/21 at 12:30 p.m. V1 stated, "(R5) exited out of the laundry room exit door. The alarms did not go off because the door was partially propped open. If the door had been completely shut the alarm would have went off when (R5) went through it."

On 11/9/21, V1 (Administrator) provided a list of residents who are at risk for elopement and have a elopement risk device. This list included the following residents: R1, R5, R11, R12, R13, and

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