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
	IL6005722	A. BUILDING: ______ B. WING ______	C 07/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOFT REHABILITATION & NURSING	700 NORTH MAIN STREET EUREKA, IL 61530

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S 000	Initial Comments Facility Reported Incident Investigation of 6/18/23/IL161961.	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 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 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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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 are not met as evidenced by:

Based on observation, interview and record review, the facility failed to supervise a moderately cognitively impaired high fall risk resident with known wandering and exit seeking behaviors, failed to ensure exit door alarms were on and activated at all panels in the facility to ensure the alarm could be heard throughout the facility, and failed to ensure a facility exit door that contained the facility's electronic wandering door management system was completely closed allowing the electronic wandering door management system to work as designed. These failures resulted in R1 exiting the facility without staff knowledge through two separate facility exit doors. R1 exited out of the facility, traveled approximately 330 feet, through a parking lot, into an apartment complex and up to the second floor. R1 was out of the facility for one hour and 23 minutes without staff knowledge. The facility was

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not aware that R1 was missing from the facility until the facility received a phone call from a resident of the apartment complex. These failures have the potential to affect 10 residents (R1-R10) who have been identified by the facility as at risk for eloping.

Findings include:

The facility's "Elopements and Wandering Residents" Policy, revised 12/6/22, states, "Policy: This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Definitions: Wandering is random or repetitive locomotion that may be goal-directed (e.g. the person appears to be searching for something such as an exit) or non-goal directed or aimless. Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e. an order for discharge or leave of absence) and/or any necessary supervision to do so. Policy Explanation and Compliance Guidelines: 1. The facility is equipped with door locks/alarms to help avoid elopements. 2. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. 3. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring the effectiveness and modifying interventions when necessary. 4. Monitoring and Managing

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Residents at Risk for Elopement or Unsafe Wandering a. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team. b. The Interdisciplinary Team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. c. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. d. Adequate supervision will be provided to help prevent accidents or elopements."

The Electronic Wandering Door Management System Manual dated August 25, 2020, documents when the door system receives a response from the resident's pendant, the door will lock, and an alarm will sound. This same manual documents that if the electronic wandering door management system has open contacts the magnetic lock will be disabled, and the exit will not be locked.

The facility's "Elopement Risk Listing" documents R1-R10 as at risk for elopement. This same listing documents R1-R10 wear electronic wandering transmitter bracelets.

On 7/22/23 at 8:16 AM, R1 was sitting in R1's wheelchair at a table in the main dining room eating breakfast. An electronic wandering transmitter bracelet was noted to R1's left ankle.

On 7/22/23 at 8:24 AM, R1 was lying in bed in R1's bedroom. R1 stated, "they said I escaped. I don't remember doing that. I got nothing to run away from. I don't know where I would have been

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going."

On 7/25/23 at 3:03 PM, R1 was propelling R1's self in R1's wheelchair near the nurses' station and down the 300 Hallway. R1 stated, "I'm just exploring."

R1's Facesheet documents R1 admitted to the facility on 4/13/23. This same Facesheet documents R1 with diagnoses to include but not limited to: Left Femur Fracture; History of Falling; Type II Diabetes Mellitus; Altered Mental Status; Vascular Dementia; Schizoaffective Disorder; and Major Depressive Disorder.

R1's Brief Interview for Mental Status (BIMS) Assessment dated 5/8/23 documents R1 with "moderately impaired" cognition, scoring an 8/15.

R1's Fall Risk Assessment dated 5/11/23 documents R1 is a "high risk for falling" and "overestimates or forgets limits."

R1's MDS (Minimum Data Set) Assessment dated 5/8/23 documents R1 is moderately cognitively impaired, requires extensive assistance of two plus persons physical assist for transfers to and from wheelchair and standing position, and is not steady and only able to stabilize with staff assistance for moving from a seated to standing position and for surface-to-surface transfers, and uses a wheelchair as a mobility device.

R1's Elopement Risk Assessment, dated 5/4/23, documents R1 as a "high risk" for elopement. This same assessment documents R1 has made one more elopement attempts in the last year.

R1's Wandering Risk Assessment, dated 5/4/23,

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documents R1 as a "moderate risk for wandering." This same assessment documents R1 is forgetful/short attention span and R1 is a known wanderer or has a history of wandering.

R1's current Care Plan states, "I wander/exit seek/attempt to go out of exit doors (6/18/23) with no rational purpose, seemingly oblivious to my needs or safety throughout the healthcare center. Interventions: When I begin to wander, attempt to engage me in an activity or something that will hold my interest." This same Care Plan documents R1 has poor impulse control and decision making control; moderately impaired cognitive status; poor safety awareness; and R1's discharge to the community is not feasible.

R1's "Social Service Assessment and History" signed and dated by V17 (Social Service Director) on 4/17/23 documents R1 with "Behavior Factors" of "wandering" and "exit seeking".

R1's Progress Note on 4/15/23 at 4:42 PM, documents R1 was wandering in R1's wheelchair exit seeking stating that he was trying to go see his wife in the apartments. An (electronic wandering transmitter bracelet) was applied to R1's left wrist for safety.

R1's Progress Note on 4/23/23 at 1:34 PM states, "This nurse began looking for (R1) and was able to find (R1) in the downstairs men's restroom. (R1) was on the floor on his knees with his elbows up on the seat of the wheelchair. (R1) reports that he was trying to go to the bathroom, and he fell."

R1's Physical and Occupational Evaluations completed at the local area hospital, both dated 5/2/23 documents recommendations that R1

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would benefit from returning back to the skilled nursing facility due to Decreased Cognition, Poor Safety Awareness, Impaired Gait, Difficulty with Transfers, Balance Deficits, Difficulty With Bed Mobility and Decreased Ability To Perform ADLs/Activities of Daily Living.

R1's Fall IDT/Interdisciplinary Note on 5/23/23 at 11:07 AM documents R1 was found on the floor in the dining room. This same note states, "(R1) attempted to stand up without assistance, lost balance and fell. (R1) has poor safety awareness, unsteady gait, impulsive and impaired cognition. BIMS is 8 (moderately impaired cognition). (R1) requires one assist with transfers."

R1's "Geriatric Rounding Service Note" signed and dated by V21 (R1's Physician) on 6/1/23 states, ""Plan: (R1's) Memory seems worse than I would expect right now." "We are going to continue to watch (R1) and see if anything else changes. We will get a BIMS and see how he does on that, but we will need to watch."

R1's Behavior Progress Note on 6/7/23 at 1:29 PM states, "Behaviors Observed: Self transferring; (R1) caught twice by staff this shift transferring without assist, both times wheelchair wheels not in the locked position. (R1) has a hx (history) of non-compliance with call light system and asking staff for assistance, also (history) of falls during attempted self-transfers resulting in injuries."

R1's Behavior Progress Note on 6/17/23 at 3:00 PM states, "Behaviors Observed: Exit seeking, (R1) found by staff on Hall One, (electronic wandering door management system) alarming at exit door. Staff assisted resident to common area and (V3/Licensed Practical Nurse) attempted

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resident education about going down that hall. (R1) was not able to verbalize understanding of education."

R1's Social Services Note on 7/13/23 at 5:18 PM states, "(R1) is a long-term resident. (R1) has impaired cognition. (R1) is monitored for behaviors and has had some incidents recently." "He is on frequent checks as he wanders and is an elopement risk."

R1's Incident Report, dated 6/18/23 at 9:55 AM, documents R1 eloped from the facility. This report documents facility staff received a phone call from a tenant at nearby apartments that there was a male person looking for his sister in the apartment building. The male was described as wearing gray sweatpants and a white clothing protector. Facility staff arrived at the apartment building and R1 was on the second floor, sitting in a chair in the common area. This same report documents R1's "Predisposing Situation Factors" as "active exit seeker"; "wanderer"; and "ambulating without assist" and documents "Predisposing Physiological Factors" as "gait imbalance"; "impaired memory"; and "confused."

The facility's "Initial" Report to the local State Agency, undated, documents that on 6/18/23 at 9:53 AM, R1 was found in a nearby apartment building and that an investigation was initiated.

The facility's "Five Day Follow-Up" Report to the local State Agency, undated, documents an Incident Date and Time of 6/18/23 at 9:53 AM with R1. "Brief Description of Incident: (R1) exited main building of campus and was observed at campus apartments by tenant (V8)." This report states, "Investigation Complete. (V1/Administrator) did full walk-through to

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determine root cause of (R1's) ability to navigate to the apartment section of the complex. All staff on site at time of incident interviewed and it was determined that (R1) was last seen at breakfast in the dining room and then stated he was going to the Activity Room. (R1) did not enter Activity Room. (R1) wheeled down vacant rehab hallway and pushed on the door for 15 seconds until it opened. (R1) exited into another hallway and out an exit door to walkway that leads to apartments. (R1) navigated through the community room in the apartments and down a hallway. Apartment resident (V8) called nursing staff and let them know (R1) was over at the apartments. Nursing staff then retrieved (R1) and returned (R1) to the nursing home." "(R1) not able to recall leaving the nursing home area of the complex due to intermittent confusion. (V7/Maintenance Director) performed a full facility check of door alarm system and (electronic wandering door management system). It was determined that a faulty door latch allowed (R1) to exit to the outside. Door latch immediately repaired. (V1) in-serviced all staff on Elopements and Wandering Residents Policy and door safety checks. Two outside vendors called to evaluate door alarm system for needs."

The facility's "Staff Interviews" as part of V1's investigation into R1's elopement, dated 6/18/23 documents an interview with V19 (Dietary Manager). The interview states, "I last saw (R1) at breakfast this morning, (R1) was fine just eating in the dining room. However, last night (R1) was in the dining room at dinner and afterwards he was trying to get out the doors down there, so I brought (R1) upstairs myself."

The facility's "Staff Interviews" as part of V1's investigation into R1's elopement, dated 6/18/23

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documents an interview with R1. R1 stated that on 6/18/23, R1 had R1's" leg checked". R1 stated, "I put the wheelchair in my van and drove to the Children's Hospital where they took my bandage off and checked my leg, they said everything looks great and then I put the wheelchair back in my van and drove home to (name of neighboring town)."

The facility's "Root Cause Analysis Report", dated 6/19/23, documents a nature of violation as "Resident Elopement and Wandering." This same report states, "Event Description: (R1) left breakfast in the dining room around 8:20 AM stating he was going to activities. At 8:22 AM, we see (R1) heading down Hall 6 (vacant rehab hallway). At 8:30 AM, we see (R1) pushing on the door at the end of Hall 6 for 15 seconds until it opens. Door alarm sounds, but no staff or residents are currently on Hall 6 as it is vacant due to low census. (R1) proceeds to exit through the next exit door that leads outside to a small garden area and into parking lot near rehab gym. (electronic wandering door management system) alarm sounds, but door does not lock due to door was not latched. According to findings, it is assumed that (R1) then wheels around the edge of the parking lot to the next door, which is the door to the community room in the apartments. He enters through two doors into the community room, wheels through the empty community room and down a hallway through the door to the stairs. (R1) then parks his wheelchair under the stairs and proceeds to the 2nd floor. We (facility staff) are not sure if he climbed the stairs or went back down the hallway and found the elevator. (R1) then is discovered by an apartment resident (V8). At 9:53 am, (V8) calls (facility phone number) and speaks with the nurse (V3/Licensed Practical Nurse), stating she believes one of our residents

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is over there (at apartment complex). (6/18/23) 10:00 AM, (V3) calls Administrator (V1) to alert her of incident and to let her know (R1) is safe and uninjured. (V3) and three CNAs (Certified Nursing Assistants/V5, V9, and V10) immediately head over to the apartments to retrieve (R1). At 10:14 AM, (V3, V5, V9, V10 and R1) return through the Hall 6 door and back upstairs. (V4/Registered Nurse) performs full body assessment on (R1) with no new findings or injuries."

R1's Progress Note, signed and dated by V20 (R1's Family Nurse Practitioner) on 6/20/23 states, "Chief Complaint: Elopement. History of Present Illness: (R1) was seen today at (name of skilled nursing facility) to elopement. (R1) wandered outside to an apartment building and made it to the second floor before someone noticing. (R1) reports he was bored, he's a guy and he wanted to leave this place. (R1) states he will try not to escape again."

On 7/22/23 at 10:18 AM, V8 (Resident of Community Apartments) stated, "(On 6/18/23), I was coming down the hallway on the second floor of the apartments where I live. I saw a gentleman (R1) sitting there. I went downstairs and saw another tenant of our apartments and I told her to go upstairs and see that man (R1). I know we have had some new residents lately and I don't know everyone here, but he just seemed like he didn't belong. He stated he was trying to find his sister. I saw that he had a (clothing protector) on and then I knew he was a nursing home resident. I called over to the facility and gave the description of what he was wearing, and the girls (nursing home staff) came over right away to come get him. His wheelchair was found sitting at the bottom of the stairs that lead to the second

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floor. Our security cameras were struck by lightning, so our cameras were not working. I don't know how he managed to get all the way over to our building and onto the second floor."

On 7/22/23 at 10:57 AM, V3 (Licensed Practical Nurse) stated, (On 6/18/23) a tenant of the apartments (V8) next to our facility called and said a man wearing gray sweatpants, a black T-shirt and a clothing protector was looking for his sister at the apartments. I talked to (V8) the whole way there so she could guide me on how to get to (R1). We found (R1) on the second floor of the apartment building, sitting in a chair by the elevator. At the time, we weren't able to locate (R1's) wheelchair. (R1) doesn't ambulate well. I couldn't understand how it happened. We found his wheelchair at the bottom of a stairwell. I guess he climbed those two flights of stairs. No alarms were sounding upstairs at the nurses' station. (R1) was last in the dining room eating breakfast and then he was going to go to activities." V3 confirmed R1 is a known wanderer and exit seeker and states, "(R1) has triggered alarms before." At this time, V3 verified V3 did not know R1 was out of the facility prior to V8 calling the facility.

On 7/25/23 at 1:16 PM, V3 stated that R1 is not able to make sound judgements and would not be safe in the community due to R1's cognition status. V3 stated on 6/17/23, V3 responded to alarms sounding at an exit door at the end of the 100 hallway, which is a non-resident care area. V3 stated R1 was found at the exit door and R1 was not able to state what R1 was trying to do. V3 stated, "If I hear an alarm, that's the only time I run. If the alarms were on and the door was closed, (R1) wouldn't have been able to get out." V3 stated V3 has never heard an alarm sound at

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(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
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the facility's door alarm panel at the nurses' station because it is never on. V3 verified if the panel was on and working properly, V3 would have been able to hear an alarm that the 600 Hallway exit door had been opened.

On 7/22/23 at 11:08 AM, V4 (Registered Nurse) stated, (On 6/18/23), (R1) was up and heading downstairs for breakfast. I told (R1) I needed to see him after breakfast to look at his dressing. (V3) got the call about (R1) being in the apartments, I stayed in the facility with the other residents. I was not aware that (R1) was missing from the facility prior to (V8) calling." V4 verified that V4 did not hear any alarms sounding in the facility. V4 stated, "If I heard an alarm sounding, I would have investigated it right away."

On 7/22/23 at 11:17 AM, V6 (Certified Nursing Assistant/CNA) stated on 6/18/23, V6 last saw R1 in the dining room eating breakfast around 8:15 AM. V6 stated that V6 stayed upstairs with the other residents but that V6 saw R1 eating when V6 was in the dining room taking another resident back upstairs. V6 denied hearing any alarms sounding upstairs. V6 denied that anyone would be able to hear the door alarms downstairs from the upstairs. V6 stated, "There is a panel at the nurses' station that would tell you where the door alarm is going off, but it did not work that day."

On 7/22/23 at 11:45 AM, V7 (Maintenance Director) stated, "I came in (on 6/18/23) when they notified me about (R1). No alarms were sounding at the nurses' station panel. The alarms are always sounding without reason, so the alarm panel is shut off. It has been brought to Corporate's attention many times. Alarm companies provided bids to Corporate to have the system replaced. I have been at the facility for

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	IL6005722	A. BUILDING: ____ B. WING ____	C 07/28/2023

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six months and the alarm system hasn't worked right since I have been here. I understand it's been like that for years. The panel would have alarmed at the nurses' desk with the location of the opened door. The second door has the (electronic wandering door management system). Since the door wasn't closed properly, the (electronic wandering door management system) couldn't work as it should. Normally the door would magnetize shut so it cannot be opened, but that function couldn't work as intended because the door was already opened. The alarms were sounding at the doors, but no one would ever hear that upstairs at the nurses station. The second door latches shut. Someone went out that door and didn't make sure to check that it closed behind them. I did tighten some hinges, but it wasn't door error, it was employee error."

On 7/22/23 at 8:10 AM, V15 (Activity Assistant) stated that on 6/18/23, V15 worked in the Activity Room until 12:00 PM. V15 stated that V15 received a call from V1 (Administrator) asking if R1 was in activities. V15 stated, "I guess he (R1) got out (of the facility). (R1) came to BINGO on Saturday (6/17/23) but he didn't want to come to church on Sunday. I never heard any alarms sounding (on 6/18/23) I couldn't hear those door alarms from here."

On 7/22/23 at 12:20 PM, V5 (CNA) stated that on 6/18/23, R1 was down at breakfast helping feed residents in the corner. After breakfast, V5 went upstairs to chart. V5 stated the facility got the call about R1 being found at the apartments. V5 stated R1 went out of the back doors by Hall 6. V5 stated, "Normally the door would have locked because of the (electronic wandering door management system) and it alarms. No alarms were heard upstairs. I went with (V3) to go get

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(R1) from the apartments. He was sitting in a chair on the second floor. The nurse stayed with (R1), and I went to go look for his wheelchair. We couldn't find it, so we borrowed one of theirs (apartment complex). We ended up finding it by a flight of stairs." At this time, V5 verified that V5 did not know R1 was missing from the facility prior to V8 calling.

On 7/25/23 at 1:00 PM, V10 (CNA) stated that on 6/18/23, V10 saw R1 eating breakfast downstairs in the main dining room when V10 was bringing other residents down to eat. V10 stayed on the main floor helping to pass room trays, drinks, and answer call lights. V10 denied that any alarms were sounding on the main floor to alert staff that a door had been opened. V10 stated the alarm panel at the nurses' station is very loud and that if it had been on, you would have been able to hear it from anywhere upstairs. V10 stated the facility received a phone call from a resident of the apartments who saw "a man with a clothing protector on who was looking for his sister." V10 stated V10 went with V3 to the apartment complex to locate R1. V10 stated, "We immediately went over there (to the apartments) and found (R1) sitting in a chair in the lobby area." V10 stated R1's wheelchair was not immediately able to be found. V10 stated prior to R1's elopement from the facility, R1 would often wander and make comments about waiting to get picked up from the facility. V10 stated if the second door would have been closed, R1's (electronic wandering transmitter bracelet) would have caused the door to lock and R1 would not have been able to open it. V10 stated R1 is able to propel R1's self in R1's wheelchair but that R1 normally requires staff assistance to stand. V10 stated, "(R1) is stubborn and will sometimes try and transfer himself." V10 stated R1 is not safe

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on R1's own outside of the facility. V10 denied being aware that R1 was missing from the facility prior to getting the phone call from V8.

On 7/25/23 at 1:59 PM, V17 (Social Service Director) stated that R1 came to the facility as a transfer from another local area skilled nursing facility. V17 stated that R1's plan is long term with no plans for discharge. V17 stated that R1 is not safe in the community due to R1's lack of safety awareness. V17 stated R1 has a history of falls and requires assistance to and from the bathroom, in and out of bed, and requires cueing for mealtimes. V17 stated R1 recently began displaying sexually inappropriate behavior that is being managed by an outside psychiatric company.

On 7/26/23 at 9:50 AM, V18 (R1's Power of Attorney/Spouse) stated that V18 was called and informed that R1 had gotten out of the facility (on 6/18/23) and R1 was found in a nearby apartment complex. V18 stated that R1 does have a sister who lives in a neighboring city and due to her health status, she has not been able to visit R1 in over a year. V18 stated, "(R1) gets very confused. (R1) cannot take care of himself. That's how he got to be in the facility in the first place. (R1) needs around the clock care, he isn't safe on his own. I couldn't provide that for him at home. I try to get in and visit (R1) at least once a week. (R1) often makes comments about going out to get his truck and sometimes thinks we are still living in California. His brain is fried, and it happened so fast."

On 7/26/23 at 10:27 AM, V19 (Dietary Cook) stated that V19 was working in the facility on 6/18/23. V19 stated, "We had just served the breakfast meal and the CNAs were in the corner

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S9999	Continued From page 16 assisting the residents who need fed. I turned around and (R1) was just gone. It's like he just disappeared. I didn't think anything of it and assumed (R1) went back upstairs. That's what the independents do. I didn't see him leave the room. I started preparing the next meal and then next thing I know, I see (V1/Administrator) standing there. I knew something must have happened if (V1) was in on a weekend. I did not know that (R1) was missing. They said he got out (of the facility). Normally if (R1) got close enough to the doors, they would lock shut automatically because of his (electronic wandering transmitter bracelet) and the doors would alarm. We have to enter a code to get the alarms to reset." At this time, V19 denied hearing any alarms sounding on 6/18/23 when R1 exited out of the facility doors. V19 stated, "You can't hear the hall 6 alarms in the dining room." V19 stated, "The day before (6/17/23), he (R1) was trying to get through the exit doors in the dining room. He was talking off the wall, saying silly things like he wanted to go to Washington or California and that he had kids that he needed to get candy to. I told one of my co-workers that I was worried about (R1) because he was not making any sense. I took (R1) directly upstairs myself and told the nurse at the nurses' station to keep an eye on him because he was trying to leave." er On 7/22/23 at 8:42 AM, V1 (Administrator) stated that V1 was called on a weekend (6/18/23) and informed that R1 was found out of the facility. V1 stated that at the time, Hall 6 was closed for resident use due to low census and therefore, staff were not present on the hallway. V1 stated that R1 had reported to staff that he was going to Activities. V1 stated that after a review of the video camera surveillance footage, R1 instead proceeded down the 600 Hallway. V1 stated that	S9999		

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R1 pushed the first emergency exit door for 15 seconds, allowing it to open. V1 stated the second door wasn't completely latched closed, therefore R1 was able to exit out of the door, to the outside. V1 stated that V7/Maintenance Director did tighten some hinges on the door but is unknown why the door did not latch completely close. V1 stated that no alarms were able to be heard upstairs in the facility, only at the doors themselves. V1 stated that the door alarms where R1 exited the facility from are not loud enough to be able to be heard from the Activity Room. V1 reported inquiring about the alarm volume being adjusted but was told this is not a capability of the alarm system. V1 stated that R1 was gone from the facility a little over an hour before the facility received the phone call from the apartments and staff became aware that R1 was not in the facility. V1 stated, "There is an alarm system for the doors as well that would alarm at a panel at the nurses station. Unfortunately, the door alarm panel was shut off manually by someone. The alarms were always going off, even without the doors being opened and staff were always having to check the doors, and nothing was causing the alarms to go off. The wind would blow the wrong direction and trigger the alarms. It has been like that for years. It is old and needs replaced." At this time, V1 verified that if the exit door alarms were functioning appropriately and activated at the nurses' station and if the door that contained the facility's electronic wandering door management system was completely closed, R1 would not have been able to leave the facility supervised. V1 stated, "(R1) wouldn't have been able to get out."

On 7/22/23 at 8:57 AM, this surveyor viewed the route R1 took to exit the facility alongside V1 (Administrator). After walking out of the 600

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Hallway facility exit door, a sidewalk bordered with rock walls leads to a paved parking lot. The apartment complex where R1 was located sits to the left of the parking lot, atop a small incline, 150 feet from the facility exit doors. A residential street and housing are noted to the immediate right off the parking lot. Immediately upon entering the apartment complex doors, storage boxes, tables, stacked chairs and old televisions sitting on the floor filled the room. The stairwell where R1's wheelchair was located opened to a hallway that led to the location where R1 was found. This stairwell consisted of two flights of stairs with metal railings, metal edges on the front of each step and concrete walls and floors. The distance from the facility exit doors where V1 stated R1 exited the facility to the location where R1 was located was approximately 330 feet.

On 7/22/23 at 9:10 AM, V1 (Administrator) showed this surveyor the alarm panel at the facility's nurses' station. The alarm panel consisted of individual buttons, each labeled with the location of the door it correlated with. V1 stated if an emergency exit door was opened without entering a code at the door prior, the correlating button would illuminate and sound to notify staff which emergency exit door was opened. At this time, V1 verified that all alarm buttons were compressed into the off position resulting in no alarm being able to sound to alert staff that an emergency exit door anywhere in the facility had been opened. V1 turned all the alarm buttons into the on position and immediately three different buttons, labeled with the location of the door illuminated and sounded very loudly. At this time, V1 stated, "This is why the alarm panel is shut off, the doors alarm without reason. It needs replaced." V1 again placed all alarm buttons on the panel back in the off position.

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S9999	Continued From page 19 On 7/25/23 at 3:00 PM, V7 showed this surveyor the alarm panel at the facility's nurses' station. The panel buttons were in the off position including the 600 hallway/therapy exit. At this time, V7 verified any emergency exit doors that would be opened would not be able to be heard at the nurses' station. V7 stated, "This whole system is antiquated. It needs replaced. Corporate knows." (B)	S9999		