STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012827	A. BUILDING _____ B. WING _____	C 04/20/2023

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AVANTARA OF ELGIN	1950 LARKIN AVENUE ELGIN, IL 60123

(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
S 000	Initial Comments Complaint Survey: 2373070/IL158661	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6 300.2210b)2 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 care and personal care shall be provided to each 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. Section 300.2210 Maintenance b) Each facility shall: 2) Maintain all electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems in safe, clean and functioning condition. This shall include regular inspections of these systems. These Requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to supervise residents with wandering and elopement risks. The facility also failed to provide adequate supervision to prevent elopement from the facility. The facility failed to ensure all facility's exit door alarm systems (9 exit doors) were maintained in	S9999		

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S9999	Continued From page 2 functioning order to alert staff and able to respond to residents exiting the facility. The facility also failed to follow its elopement policy by not determining the cause of the triggered alarms, failing to monitor safety alarm systems to ensure they function, and assessing residents for risk of elopement behavior. This applies to 6 of 6 residents (R1, R2, R3, R4, R5, R6) reviewed for supervision/elopement risk in the sample of 19. R1 and R2, a husband and wife, both confused, with diagnoses of dementia, were wandering and unsupervised along well-traveled community roads when found by police officers due to a call from a concern citizen. R1 and R2 were a mile away from the facility when they were found. R1 and R2 were outside on a 4 lane well-traveled road with major intersections. This road included a hospital on one side of the road and a school on the opposite side and R1 and R2 also passed through roads that were elevated and hilly areas, with no walkways between pedestrians and vehicles. The police report shows that R1 and R2 were unsupervised and away from the facility caretakers for a period of approximately 90 minutes. The facility failed to report R1 and R2 were missing to the police department. The police determined which facility R1 and R2 resided. The clinical record dated 4/11/2023 shows that R1 and R2 was last seen by facility staff at 4:30 P.M., overhead paged for CODE YELLOW ALERT (missing residents) at 5:45 P.M. and police officer called facility at 6:25 P.M. to informed them they found R1 and R2. This was a two-hour duration that R1 and R2 was without supervision from staff. R1 refused to go back to the facility, hence, was taken to the hospital, but later was returned to the facility. R2 was picked	S9999		

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S9999	Continued From page 3 from the location where she was found by a facility staff and returned to the facility at 7:30 P.M. The findings include: R1, an 85-year-old with diagnoses of dementia with behavioral symptoms, encephalopathy, cognitive communication deficit, PTSD (post-traumatic stress syndrome), paranoid personality disorder, altered mental status, anxiety disorder, depression, CKD (chronic kidney disease), gout, unsteadiness of feet, and lack of coordination. R1 was admitted to the facility on 3/7/2023 from hospital admission on 2/27/2023 due to aggressive, belligerent behavior, confusion and change in mental status. The MDS (Minimum Data Set) dated 3/9/2023 shows R1's BIMS (Brief Interview Mental Status) score of 3/15 (severely impaired); with moods of feeling down, trouble falling asleep, feeling tired, poor appetite that were exhibited in 12 out of 14 days duration. R1 was also assessed with poor balance when moving around from surface to surface, transfers, and walking. R1's primary locomotion was a wheelchair. The EMR (Electronic Medical Record) of R1 have multiple physician progress notes that show the following: -3/13/2023; R1's dementia is getting worse -3/15/2023; R1 with aggressive behavior; will need Long Term Care Memory Care Unit. -3/15/2023; R1 was looking for papers to take to the bank -3/17/2023. R1's initial psychiatric visit in the facility: "HISTORY OF PRESENT ILLNESS: (R1) is an 85-year-old male, with past medical history of: HTN (hypertension), HLD (hyperlipidemia),	S9999		

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S9999	Continued From page 4 Gout, Colon Cancer s/p Colon Resection, CKD3, mild Dementia, Depression, left hip fracture with repair 9/2022, who present to (hospital) on 2/23/23 from PCP (primary care physician) office with confusion. (R1) was initially sent to ED (Emergency Department), due to altered mental status. (R1) was transferred to another hospital for further evaluation. (R1) was very belligerent and uncooperative, requiring Haldol (antipsychotic medication to treat schizophrenia and help rebalances and improve thinking, mood and behavior). (R1) was seen by Psychiatry and was diagnosed with dementia with behavioral disturbance. (R1) was started on Depakote, Risperdal, Trazodone, Donepezil (antipsychotic/mood stabilizers medications) ...." -3/27/2023: R1 with aggressive behavior -4/3/2023: There were 2 notes on same day that R1 continues to ask to go home -4/6/2023; R1 was fixated going home -4/7/2023; R1 needed a secured unit due to dementia -4/10/2023; Further notes showing that R1 was fixated going home Review of R1's elopement risk assessment log shows that comprehensive elopement assessment was not done until R1 had eloped on 4/11/2023. Despite of the multiple notes from physician provider that R1 was fixated of going home with worsening dementia, the facility failed to assess R1 and provide preventative measure to prevent elopement. The care plan also shows that it was only on 4/13/2023 that interventions which included a monitoring alarm safety device to be applied, which obviously will not work since the facility was not equipped with detecting this monitoring alarm device. The EMR shows that R2, an 80-year-old female,	S9999		

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S9999	Continued From page 5 wife of R1, was originally admitted to the facility on 3/9/2023. R2's diagnoses included but not limited to Alzheimer's disease, worsening dementia, anxiety disorder, major depressive disorder, lack of coordination, abnormality of gait and mobility, unsteadiness of feet, bilateral hearing loss, malignant neoplasm of breast, and gastrointestinal bleed. R2 was sent out to the hospital and was admitted from 3/22-27/2023. R2 returned to the facility on 3/27/2023. The MDS dated 3/11/2023; 3/17/2023; and 3/29/2023 shows that R2's BIMS (Brief Interview Mental Status) score of 5/15 (severely impaired); with moods of feeling down, trouble falling asleep, feeling tired, poor appetite that were exhibited in 12 out of 14 days duration. R2 was also assessed with poor balance when moving around from surface to surface, transfers, and walking. R2 was ambulatory and does not use assistive devices for ambulation. R2 was assessed requiring assistance from staff for her ADLs (Activities of Daily Living). The EMR of R2 have multiple physician progress notes that show the following: -3/5/2023; R2's insight was poor -3/14/2023; "wander guard (monitoring alarm safety device ....)" -3/15/2023: needs memory care unit -3/30/2023: "(R2) wants to go home with Bill (R1, the husband)" -4/3/2023: "(R2's) dementia is getting worse; has extreme short memory loss, need memory care unit placement, is Elopement Risk" -3/27/2023: has order for monitoring alarm safety device received by V10 (RN). The assessment log from 3/9/2023 through 4/13/2023 shows that Elopement Risk was not	S9999		

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S9999	Continued From page 6 done until 4/11/2023 after R2 had eloped. The care plan dated 3/10/2023 shows that R2 was to be applied a monitoring safety alarm device on 3/27/2023. The order was obtained by V10 (RN/Nurse). There was no documentation that the device was applied, monitored, or checked whether the exit door can detect the alarm device if R2 passes by. When interviewed on 4/14/2023 at 1:48 P.M., V10 said he does not remember if R2 wears the device nor had check if it was applied. The incidental progress note report dated 4/11/2023 shows "at about 1630 (R1 and R2) not being seen in the facility, resulted in massive searching, in the building and around. patient was later found by the police and taken to the hospital for assessment." The social service notes dated 4/11/2023 shows that "(R1 and R2) was last seen by facility staff at 4:30 P.M., overhead paged for CODE YELLOW ALERT (missing residents) at 5:45 P.M. and police officer called facility at 6:25 P.M. to informed them they found (R1 and R2). On 4/13/2023 at 10:45 A.M. R1 and R2 were observed in their room. R1 was sitting in his wheelchair. When asked his name, R1 did not response. R1 was asked what his current location was, R1 responded with a loud voice "HELL!" R1 continued to yell saying he was on his way "TO HELL" when he left the placed with his wife (R2). For the meantime, R2 was telling R1 to "shut up, this lady is trying to help us." R2, knows her name, but does not know her location, time and no idea of the staff around her. When R2 was asked why they left the facility on 4/11/2023, R2 had no response and have a confuse look on her	S9999		

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S9999	Continued From page 7 face what the surveyor was talking about. On 4/13/2023 at 11:00 A.M. V2 (Director of Nursing) showed to surveyor the exit door where R1 and R2 had exited. The exit door was called Southwest (SW) Exit door. This exit door was about 15 feet away from the SW nurses' station. There was also a wall that faces the exit door and was blocking the visibility whoever is entering or exiting the SW exit door. It is only through an alarm system to alert staff and detect anyone opening this exit door. The 300 residents' hallway connects vertically to the SW nurses' station and 200 hallway connects perpendicular to same nurse's station. The panel for the alarm system was located attached to the wall in the SW nurse' station. The panel for the alarm system was to help identify which exit door the alarm was triggered. During this observation, V2 had open the SW exit door, and alarm was triggered. There was no staff who came to check for the panel system nor check the SW exit door. Furthermore, the alarm sound was not audible to 200 and 300 hallways. These are the hallways that are of proximity to the SW exit door. After V2 had turned off the alarm, V6 (LPN/License Practical Nurse) came to the SW nurse' station. V6 said that the "SW exit door alarm was not audible and if you are next to the SW exit door, you are lucky to hear that faint alarm. The alarm sound is also confusing because it sounded like an oxygen being administered or a gastric tube pump that was beeping." V6 said that she had worked around 300 hallway when R1 and R2 had eloped, but she did not hear the alarm sound. Together with V2, staff that had worked on 4/11/2023 when R1 and R2 had eloped were identified. Interviews were held with these staff on 4/14/2023 and 4/15/2023.	S9999		

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S9999	Continued From page 8 -at 1:48 P.M, V10 (Registered Nurse/RN) said he was assigned to R1 and R2 the evening shift of 4/11/2023. V10 said he saw R1 and R2 wandering around the hallways of all units of the facility with R2, pushing R1 in a wheelchair. V10 said that he was not aware of their elopement risk. V10 said he was not aware that R2 wears a monitoring safety device and nor had checked if she has one. V10 said that he last saw them around 4:00 P.M. when he was passing medications. -at 2:08 P.M., V11(CNA/Certified Nurse Assistant) said that she was the assigned CNA for both R1 and R2 on 4/11/2023 for the evening shift. V11 said that she saw them wandering around all units of the facility. V11 said that she found out they were missing when R1 and R2's dinner trays were left in the dinner cart after she passed trays for her assigned residents. V11 said she then started to look and asked other staff if they saw R1 and R2 since she cannot find them. V11 said that this was 5:00 P.M. when she was done passing dinner trays and realized that R1 and R2 were nowhere to be found. V11 said she did not hear an alarm from any exit door. V11 also said that she did not know that R2 wears the monitoring safety device nor had checked R2 is she wears one. V11 said she did not know that R1 and R2 were elopement risk. V11 said that she last saw them at 4:00 P.M. on 4/11/2023. Interviews continued with other staff that worked at time of R1 and R2's elopement. They were V7 (LPN), V8 (RN), V9 (LPN), V12 (CNA), V13 (CNA), V14 (CNA), V15 (CNA), V16 (CNA), V17 (CNA), V18 (Receptionist), V19 (RN Supervisor), and V20 (Activity Director). All of them said that both R1 and R2 wanders around all the units, don't keep tract of their whereabouts, not know the time they left the facility and they do not know	S9999		

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S9999	Continued From page 9	S9999		

what time they last saw R1 and R2 the evening of 4/11/2023. Furthermore, they also said they did not hear the alarm sound off from any of the exit door nor had heard the alarm from R2's monitoring safety alarm device. There were 16 staff that were interviewed who worked the evening of 4/11/2023. They all said they did not hear any alarm that sounded off. Except one staff V7 (LPN) who said he heard a faint alarm when he was inside room 302 (300 hallway). V7 said that he came out of room 302 and a faint alarm sound was coming from the SW exit door. V7, said he started to walk towards the middle of hallway approaching the SW nurse's station and SW exit door. V7 continued to state that when he reached the middle of the hallway (room 312), the alarm sound had stopped. V7 said from where he was at, he can view the SW nurse station where the panel was located. However, V7 said he did see who turned off the alarm from the panel system. V7 also said he did pursue to find out who turned off the alarm, nor find out what was the cause why the SW exit door alarm was triggered. V7 said "someone must have turned off the alarm from the panel system, otherwise the alarm will not shut off by itself, but when I'm on the middle of the hallway (room 312), all of a sudden, the alarm had stopped, so someone had turned the alarm off." V7 also said that he did not check the SW exit door what had caused the alarm to trigger. V7 said he did not check the vicinity of the SW exit door to see possible elopement of resident/s.

After the interview with V7, V2 accompanied the surveyor on 4/14/2023 at 2:45 P.M. and checked the distance and visibility between the location of where V7 was (room 302, 312), the panel system for alarm, SW nurse station and SW exit door. It shows that room 302 was the same hallway that

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extends all the way to the panel alarm system, which was approximately 15 feet away from the SW exit door. V2 asked V3 (Director of Maintenance) to measure the distance of these locations. The distance of room 302 to the SW nurse' station was 175 feet; from room 312 to the SW nurse' station was 115 feet. V2 stated that it was impossible for V7 not to see the individual that had turned off the alarm since it was of visible view where V7's location was. V2 said that nevertheless it was still expected that V7 should have checked the SW exit door and determine what cause the alarm to trigger. V2 also said that it was also expected that V7 should have check the vicinity around the exit door for possible elopement of resident/s.

On 4/13/2023 at 1:20 P.M., V1 (Administrator), V2, V3 have all said that "someone must had turned off the alarm without checking what had caused the alarm to trigger and failed to check if any residents had eloped. If someone had checked, (R1 and R2) would have been seen immediately after they exited the door." V1 said "this is a serious matter and I do not get a straight answer from the staff. The alarm will not shut off by itself, it must be manually shut off from the panel system in the SW nurse's station to stop the alarm." V3 said "if they did what they (staff) were supposed to do and check, this would have not happened that (R1 and R2) eloped."

On 4/13/2023, at 1:40 P.M., V5 (Technician from an online communication company contracted by the facility) was interviewed with V2 and V3 present. V5 said "the alarm system in the facility is old, not capable to alert/send signal to the staff when the alarm sound off. The staff might hear if near to the exit door that was triggered, but if the staff is far beyond 6 residents' room, the staff

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might not hear the alarm. We are waiting for the parts to replace the whole alarm/panel system and install new alarm system to all (9) exit doors of the facility. This why the staff barely hear the alarm. It needed replacement." V3 commented he checks the 9 exit doors for lapse time required to close the door but did not ask staff if it was audible for all units. V3 also said that he does not check the monitoring alarm safety device if it was functioning. V3 said "all I do is order the device but not check them if they were functioning. Anyway, there were only 2 doors that were supposed to trigger (the front and SW exit doors) when a resident wearing the monitoring alarm safety device passed by these doors." V3 added that the front and SW exit doors were nonfunctioning and do not detect the monitoring alarm safety device. Surveyor asked what the facility's current implementation since their exit doors alarm and monitoring alarm safety device was not detectable. V1, V2, V3 have all said that currently they do not have a plan to monitor their exit doors to ensure that their residents that are confused and have the potential for elopement be prevented from eloping.

On 4/14/2023 at 9:30 A.M., V2 said that it is the responsibility of V3 to check the 2 doors (front and SW) if they were functional and can detect alarm for the monitoring alarm safety device. V3 was called and he said, "I fixed the alarm on the SW exit door today, because the alarm system was bent down, and it was not producing an audible sound that alert staff."

On 4/13/2023, together with V1, V2 and surveyor, the facility's video surveillance was reviewed for 4/11/2023 from 4:30 P.M. to 4:50 P.M. The video surveillance shows R1 and R2 had exited the SW exit door at 4:46 P.M. R2 was pushing R1 while

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S9999	Continued From page 12 seated in his wheelchair. The video shows that R1 and R2 headed to south parking lot of the facility. They headed to a direction that the only way out from the facility was to go to the main road. This main road has 2 opposite traffic lanes. There was also an adjacent building to this parking lot, however, the only way out from this adjacent building was to go to the same main road. The police report dated 4/11/2023 shows that R1 and R2 were unsupervised and away from the facility caretakers for a period of approximately 90 minutes. The facility failed to report R1 and R2 were missing, and with police investigation, they found out which facility R1 and R2 resides. The clinical record dated 4/11/2023 shows that R1 and R2 was last seen by facility staff at 4:30 P.M., overhead paged for CODE YELLOW ALERT (missing residents) at 5:45 P.M. and police officer called facility at 6:25 P.M. to informed them they found R1 and R2. This was a two-hour duration that R1 and R2 was without supervision from staff. R1 refused to go back to the facility, hence, was taken to the hospital, but later was returned to the facility. R2 was picked from the location where she was found by a facility staff and returned to the facility at 7:30 P.M. On 4/13/2023 at 3:00 P.M., V20 (Activity Director) said that she had picked R2 from the location where she and R1 were found. V20 said she had picked R2 on 4/11/2023 and returned to the facility at 7:30 P.M. On 4/13/2023 at 5:00 P.M., V20, V2, and surveyor drove and checked the roads and location where R1 and R2 were found. It was	S9999		

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	IL6012827	A. BUILDING: _____ B. WING _____	C 04/20/2023

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determined that it was one mile away from the facility. The route to the location shows that R1 and R2 must passed by main roads that encompasses 2 opposite traffic lanes, 2 traffic lights in major road intersections, 2 four way stop signs and a well-traveled areas as there was a hospital on one side of the road and a school on the opposite side. R1 and R2 also must passed through some roads that were elevated, hilly areas, with no walkways between pedestrians and vehicles.

R1 and R2 was transferred on 4/13/2023 to another facility that has a secured/locked unit designated for residents with diagnosis of dementia.

On 4/13/2023 at 11:34 A.M., V4 (Social Service Director) said that she did not do comprehensive elopement risk assessment for R1 and R2 until after they have eloped on 4/11/2023. V4 also said that R3 is an elopement risk, wanders around, exit seeking, and was applied a monitoring alarm safety device. When V4 and surveyor went to R3's room after the interview, R3 was sitting in a lounge chair in her room. V4 had checked R3's monitoring alarm safety device on R3's ankles and wrists and found none. V26 (R3's husband) was visiting. V26 was not aware that R3 was supposed to have the monitoring alarm safety device. V4 said to V26 that "(R3) wanders around and was sundowning so we put the monitoring alarm safety device, but it does not work so we removed it already." V4 said that R3 is provided 1:1 supervision. However, on 4/14/2023 at 1:30 P.M., together with V2, the monitoring log for the morning shift of 4/14/2023 was blank and no documentation that sitter was provided. V27 (R3's 1:1 monitoring staff) said that when she came in at 11:00 A.M., there was no one providing 1:1 to

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S9999	Continued From page 14 R3. On 4/14/2023 at 3:00 P.M., V4 was asked for other residents who were at risk for elopement. V4 said the aside from R1 and R2, the other residents at risk for elopement were R3, R4, R5 and R6. On 4/14/2023 at 5:00 P.M., V21 (Social Service Director from sister company of the facility) said she is helping V4 to ensure accuracy and completeness of residents' assessment for the elopement risk. V21 said that for the total census of 102 residents/ 79 were so far reviewed for elopement risk. V21 also said that she had 10 residents that needed to have an "extra look for elopement risk." V21 said that out of this 10, 4 residents (R12, R13, R14 and R5) do not have a completed BIMS. V21 also said that R5 is identified as an existing wanderer. V21 also said that 6 other residents were looked and reassessed because they are ambulatory and have lower BIMS score (R3, R15, R16, R17, R18, R19). The EMR of the following residents shows: -R3 is 81-year-old who was admitted to the facility on 3/14/2023. R3's diagnoses included but not limited to metabolic encephalopathy, dementia, altered mental status, cognitive communication deficit, unsteady gait and mobility, and lack of coordination. The MDS dated 3/16/2023 shows that R3's BIMS score was 99 (meaning interview not completed). The assessment continued and showed R3's cognitive skill for decision making was moderately impaired, with short-term and long-term memory problem. R3 was assessed with moods of feeling down, depressed, hopeless, trouble falling	S9999		

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asleep, feeling tired, poor appetite that were exhibited in 12 out of 14 days duration. R3 was also assessed with poor balance when moving around from surface to surface, transfers, and walking. R3 was ambulatory and does not use assistive device for ambulation. R3 requires assistance from staff for her ADLs.

The assessment log from 3/9/2023 through 4/14/2023 shows that R3's Elopement Risk was not done until 4/14/2023. The assessment was inaccurately assessed since the it was not coded correctly. It was coded as 3 (low risk elopement) versus 4 (high risk elopement). The facility policy was not followed since the elopement assessment was not done timely. It was done on 4/14/2023 wherein R3 was admitted on 3/14/2023.

The care plan dated 3/15/2023 shows that R3 was identified as elopement risk and with exit seeking behavior. The intervention shows that a monitor alarm safety device was the intervention. However, this intervention was not appropriate since the facility's exit door cannot detect the monitoring alarm safety device.

On 4/13/2023 at 11:34 A.M., R3 was in her room. V4 checked R3's monitoring alarm safety device on ankles and wrist and none was found.

R4 is a 75-year-old with diagnoses that includes but not limited to hydrocephalus, pre-diabetes, and benign neoplasm. R4 was admitted to the facility on 10/17/2022.

The MDS dated 1/17/2023 shows that R4's BIMS score was 3/15 (severely impaired). R4 was assessed with moods of feeling down, depressed, hopeless, trouble falling asleep,

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S9999	Continued From page 16 feeling tired, poor appetite that were exhibited in 12 out of 14 days duration. R4's primary locomotion was a wheelchair. R4 was able to propel his own wheelchair. The assessment log shows that R4's Elopement Risk were done on 11/16/2022 and 4/14/2023. The elopement risk was not done quarterly as per facility policy. R4 was a high risk for elopement. R5 is a 72-year-old admitted to the facility on 12/12/2022. R5 with multiple diagnoses included but not limited unsteadiness of feet, lack of coordination, diabetes mellitus, depression, repeated falls, and anxiety disorder. The elopement risk log shows that R5 was assessed for elopement on 1/11/2023 (high risk), 4/13/2023 (low risk) and 4/14/2023 (low risk). The facility policy was not followed by not assessing R5 timely. The MDS dated 12/15/2022 and 2/3/2023 shows that R5 was assessed with moods of feeling down, depressed, hopeless, trouble falling asleep, feeling tired, poor appetite that were exhibited in 11-12 out of 14 days duration. R6, a 76-year-old with diagnoses that includes but not limited to rhabdomyolysis, history of falling, unsteadiness of feet, gait and mobility abnormality, lack of coordination, cognitive communication deficit, depression, seizures, and benign neoplasm of meninges. The MDS dated 3/3/2023 and 3/27/2023 shows that R6 was assessed with moods of feeling down, depressed, hopeless, trouble falling asleep, feeling tired, poor appetite that were exhibited in 12 out of 14 days duration.	S9999		

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S9999	Continued From page 17 The elopement risk log from shows that R6 was assessed for elopement on 4/14/2023 in which policy was not followed since it was untimely done. The progress notes from the physician dated 3/7/2023 shows that R6 "planning to move to a long-term facility ...will discuss with social services. HPI: 76 y/o admitted to hospital on 2/24/23 after fall, after he lost consciousness, he believes both are related to seizure, last seizure 9 years ago, it is believed that (R6) had been on the floor for 3 to 4 days. CT (Computerized Tomography) of the head showed Carotid Calcifications ...MRI (Magnetic Imaging Reasoning) of the brain showed 1.5cm mass at level of cribriform plate without extension, meningioma." On 4/14/2023 at 1:45 P.M., V9 (LPN) stated that she noted R6 wandering around the facility with no direction where to go. The POS (Physician Order Sheet) for the month of March and April 2023 shows that there was no order for R6 to leave the facility unsupervised. On 4/13/2023 at 10:35 A.M., R6 was at the front lobby of the facility. R6 was waiting for the ambulance for a medical appointment. R6 was ambulatory. R6 was accompanied by a sitter. At 2:50 P.M., R6 was seen lying in his bed. R6 was asked about his appointment. R6 responded "what appointment." V2 was present during this observation. The facility's policy regarding elopement dated 11/01/2016, revised 7/27/2022 shows: "It is the policy of this facility that all residents are	S9999		

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S9999	Continued From page 18 afforded adequate supervision to provide the safest environment possible. All residents will be assessed for behaviors, or conditions that put them at risk for wandering/elopement. All residents identified will have these issues addressed in their individual plan of care .... Procedure. 1. Residents who have been assessed at risk for elopement /wandering shall be provided at least one of the following safety precautions by the facility; a) An adult electronic monitoring safety device will be used to notify /alert staff by sounding an alarm when the resident enters the perimeter around the alarmed door. ...b) Door alarms placed on facility exits. ...2) As part of preventative Maintenance Program, all doors will be checked for proper function daily by maintenance department .... 3. Residents with an adult electronic monitoring device will be checked every shift to ensure device is in place. 4. Adult electronic monitoring device will be checked weekly to ensure the device is functioning properly. ...5. At no time shall a door be TURNED OFF, without the continual supervision of the exit. If the alarm must be turned off, it is the responsibility of the person disarming it to make sure it is functioning properly once the alarm is turned back on ...All residents shall be reviewed for safety awareness impairment and elopement /wandering concerns upon admission, readmission, quarterly, and significant change in condition and as needed. Residents identified at risk for elopement/wandering will have a plan of care implemented to address their elopement/wandering behaviors ... When a door alarm sounds, staff members shall immediately respond to determine the cause of the alarm. The staff person responding to the alarm will check outside of the building/vicinity of the area to determine if a resident has exited the building."	S9999		

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S9999	Continued From page 19 On 4/18/2023 at 11:00 A.M. V1, V2 and V3 (Regional Operation Manager) have all stated that comprehensive elopement risk assessment was supposed to be done within 48-72 hours upon admission and as needed to determine a specific plan of care to prevent elopement. V2 and V3 also said that the admission assessment done by the admitting nurse have few questions regarding elopement, but it was not considered a comprehensive elopement assessment that would determines an elopement risk. (A)	S9999		