STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005516	A. BUILDING: _____ B. WING _____	C 06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN BARR LINCOLN PARK	2732 NORTH HAMPDEN COURT CHICAGO, IL 60614

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S 000	Initial Comments COMPLAINT INVESTIGATION: 2384608/IL160570	S 000		
S9999	Final Observations Statement of Licensure Violations: 1/2 300.610a) 300.661 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 300.661 Health Care Worker Background Check A facility shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code. This regulation is not met as evidenced by: Based on interview and record review, the facility failed to ensure Health Care Worker Background Checks were done in a timely manner and were	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 documented to prevent abuse. This failure has the potential to affect all 75 residents residing in the facility. Findings include: The facility "Daily Census" dated 6/6/23 documents, in part, that there are 75 active residents in the facility. On 6/14/23 at 3:17 pm, V29 (Human Resources Director) initiated the Health Care Worker Background Check as follows: V20's (Former Certified Nursing Assistant, CNA) paper file was reviewed. No date and time show on V20's "Illinois Department of Public Health: Health Care Worker Registry," "Individuals in Custody," "Individual in Custody Search," and "Wanted Fugitives" registry checks. V20's date of hire was 3/9/23. When asked where the date and times are that these registry checks were performed, V29 stated, "It doesn't allow me to check the date on the bottom (of these pages)." V29 stated that V29 has been in the HR Director role since 12/2022 and can see that some of the employee files that were processed prior to V29's employment do have the date and times on all Health Care Worker Registry checks. V29 stated that the Health Care Worker Background checks are done "during the interview process" of the potential employee. V3's (CNA) paper file was reviewed next by V29. No date and time show on V3's "Illinois Department of Public Health: Health Care Worker Registry," "Individuals in Custody," "Individual in Custody Search," and "Wanted Fugitives" registry checks. V3's date of hire was 1/29/23. V27's (Former CNA) paper file was reviewed then by V29. No date and time show on V27's "Illinois	S9999		

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S9999	Continued From page 2 Department of Public Health: Health Care Worker Registry," "Individuals in Custody," "Individual in Custody Search," and "Wanted Fugitives" registry checks. V27's date of hire was 5/30/23. V28's (CNA) paper file was reviewed next by V29. V28's hire date was 11/29/21 (prior to V29 working in the facility). All V28's Health Care Worker Registry documents (6) showed the date and time when the background checks were performed. V7's (Licensed Practical Nurse, LPN) paper file was reviewed then by V29. No date and time show on V27's "Illinois Department of Public Health: Health Care Worker Registry," "Individuals in Custody," "Individual in Custody Search," and "Wanted Fugitives" registry checks. V7's License Lookup was dated and timed on 3/11/23 at 12:44 pm. V7's date of hire was 3/10/23. On 6/15/23 at 2:53 pm, V29 (HR Director) reviewed 5 more employees' Health Care Worker Registry checks (V10, CNA Supervisor; V14, Restorative Nurse; V22, CNA; V23, CNA; and V26, LPN). These 5 additional employees had hire dates prior to December 2022, and their Health Care Worker Registry checks contained dates and times to confirm when the checks were performed. V29 stated, "There are 6 registries. I (V29) can't think of them all. I have a list." V29 stated, "I (V29) have to make sure they are eligible. Be in the clear with the aide registry. I look for 'work eligible.'" When asked the purpose of performing Health Care Worker Background checks, V29 stated, "To make sure the employee we are hiring are able to work with residents here. It's a safety issue." When asked if health care workers have more in-depth contact with residents, V29 stated, "Absolutely." V29 stated, "Each registry is done separately." When asked	S9999		

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S9999	Continued From page 3	S9999		

where the physical evidence of the date of checks is, "Some of them don't have dates." When asked how is V29 able to produce Health Care Worker Background check documents that were performed on the date and time that V29 performed the registry checks, V29 stated, "At the moment, I (V29) am trying to figure out how to have the date on every paper."

On 6/21/23 at 3:49 pm, V34 (Assistant Administrator) Health Care Worker Background check checks are done for perspective employees to ensure that "there's no hit for their eligibility" to work in a long-term care facility. V34 stated that staff can then work when "Human Resources has cleared them, and there's no history of being a perpetration of abuse." When asked when Health Care Worker Background checks are done, V34 stated, "I (V34) believe prior to hire." When asked what's the purpose of Health Care Worker Background checks prior to employment. V34 stated, "In case something comes up in their background." When asked how someone is to know when the Health Care Worker Background checks are being completed. V34 stated, "There's a time stamp when it's printed."

Facility policy dated 11/28/2017 and titled "Abuse and Neglect," documents, in part, "Policy Statement: It is the policy of this facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations. These guidelines include compliance with the seven (7) federal components of prevention and investigation .7

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S9999	Continued From page 4 Steps in Abuse Prevention: The seven elements of prevention and investigation include: screening, training, prevention, identification, investigation, protection, reporting/response. 1. Screening: Have procedures to: screen potential employees for a history of abuse, neglect, exploitation, misappropriation of property, or mistreating residents. This includes attempting to obtain information from previous employers and/or current employers and checking with the appropriate licensing boards and registries. Prior to placement in the facility, the facility will require background check of prospective consultants, contractors, volunteers, caregivers working on behalf of the facility, and students in its nurse aide training program. 3. Check with the Illinois Nurse Aide Registry now known as the Healthcare Worker Registry upon hire, to determine reports of abuse, neglect, and theft, if staff is not a licensed staff. 4. Initiate Illinois State Police fingerprint check for non-licensed applicants or new hires within 10 days of hiring, unless the applicant had been previously finger-printed in accordance with the Illinois background Check Act. The Illinois State Police Web Portal will automatically update convictions of those previously fingerprinted. 5. No licensed individual with a disciplinary action in effect against their license because of finding of abuse, neglect, exploitation, misappropriation or mistreatment will be employed by the facility. No individual found to be guilty in the court of law with findings of abuse, neglect, misappropriation of property, exploitation, and mistreatment will be employed by the facility." Facility job description dated 3/4/22 and titled "Human Resource Director," documents, in part, "Summary/Objective: In keeping with our organization's goal of improving the lives of the	S9999		

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S9999	Continued From page 5 Guests we serve, the Human Resource Director directs the Human Resources Department in accordance with current applicable federal, state, and local standards, guidelines, and regulations, to assure that quality personnel are interviewed, trained and employed. Essential Functions: 10. Provide public information (i.e. (that is), verification of employment). 21. Conduct and ensure employee hiring, vetting, and discharge procedures are in compliance with federal, state, and local regulations and established facility policies and procedures." (C) 2/2 300.610a) 3001210b) 300.1210d)6) 300.2900d)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	S9999		

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S9999	Continued From page 6 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. Section 300.1210 General Requirements for Nursing and Personal Care 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 300.2900 General Building Requirements d) Doors and Windows 2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. These regulations were not met as evidenced by: Based on interview and record review, the facility failed to monitor R2, a cognitively impaired resident who was a known wanderer with an electronic monitoring safety device on R2's right wrist and left ankle; failed to respond to a stairwell door alarm; failed to identify R2, who was	S9999		

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S9999	Continued From page 7 assessed at risk for elopement, on the facility's elopement risk list; failed to check the placement of R2's electronic monitoring safety device every shift per facility policy; and failed to weekly test the functioning of R2's electronic monitoring safety device per facility policy. These failures affected R2 who eloped from the facility on 6/4/23, was in an apartment 4 miles away and was returned to the facility over 15 hours later by the local police department which placed R2 at a potential risk for harm when reviewed for improper nursing care in the sample of six elopement risk residents (R2, R5, R6, R7, R8, R9). Findings include: R2's Admission Record documents, in part, that R2's diagnoses include traumatic subdural hemorrhage, cognition communication deficit, restlessness and agitation, lack of coordination, unsteadiness on feet, abnormalities of gait and mobility and repeated falls. R2's admission date to the facility was documented as 5/13/23. R2's Minimum Data Set (MDS), dated 5/20/23, documents, in part, a Brief Interview for Mental Status (BIMS) score of 2 which indicates that R2 has severe cognitive impairment. R2's Functional Status indicates that for R2's ADL (Activities of Daily Living) task like walking in room, walking in corridor and locomotion on unit, R2 is coded for a staff support of "supervision - oversight, encouragement or cueing." On 6/6/23 at 11:38 am, R2 was asked about leaving the facility (eloping) on 6/4/23. R2 stated, "R2 doesn't go outside. R2, asked again about walking out of the facility on 6/4/23. R2 stated, "R2 doesn't remember."	S9999		

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S9999	Continued From page 8 On 6/6/23 at 1:19 pm, V1 (Administrator) viewed the facility's video footage from separate video camera views as follows: 3rd floor video camera: 6/4/23 11:05 am: R2 observed walking in the hallway near the nurse's station wearing a hoodie jacket, shirt, pants, and shoes. R2 turns out of the view of video camera back towards R2's room. 6/4/23 11:06 am: V4 (Agency Registered Nurse, RN) and V5 (Agency Certified Nursing Assistant, CNA) observed at the 3rd floor nurse's station. V4 is standing outside of the nurse's station with the medication cart up against the nurse's station wall. V5 is sitting in a chair at nurse's station. R2 enters the video camera view and walks behind V4 (who's back was to R2) and walks down the 3rd floor hallway. R2 was wearing a hoodie jacket (color appears gray or pale brown), shirt, pants, and shoes. 6/4/23 11:06:50 am: R2 observed pushing the 3rd floor west stairwell door open and exiting through the door. V4 observed with V4's head down looking at the medication cart. V5 observed sitting in the nurse's station in a chair with V5's head down looking at V5's cellular phone. Neither V4 or V5 turn their heads towards the west stairwell alarm or make any attempt to respond to the alarm. 6/4/23 11:08 am: V15 (Housekeeper) observed in view next to V4 still standing at the 3rd floor nurse's station medication cart. V15 observed conversing with V4 at the medication cart. 6/4/23 11:09 am: V5 observed walking down the 3rd floor hallway. V3 (CNA) observed walking out of the bathroom directly next to the nurse's	S9999		

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S9999	Continued From page 9 station. After observing the 3rd floor video footage (from 6/4/23), V1 showed the video footage in a split screen with the 1ST floor back door, 3RD floor, and 2ND floor cameras at the same time. 1st floor video camera: 6/4/23 11:07:46: R2 observed walking out of the west stairwell into1st floor hallway. 6/4/23 11:07:56: R2 observed walking out of the first back door of the facility. V18 (Dietary Aide) observed walking in the 1st floor hallway towards the back door direction. Blue laundry bins observed in the 1st floor hallway. 2nd floor video camera: 6/4/23 11:07 am: 2nd floor nurse's station observed with several staff members sitting in chairs at the nurse's station. V1 stated, the electronic monitoring safety device alarm wasn't going off on the second floor. Parking lot camera: 6/4/23 11:08:12 am: R2 observed walking from the second back door of the facility into the parking lot. R2 walked through the small parking lot to the adjoining street (alley-like). R2 walked south (turning left) and then turned and walked north in the street. 6/4/23 11:08:53 am: R2 last observed on the facility video footage. On 6/6/23 at 11:17 am, V3 (CNA) stated, V3 was working on 6/4/23 on the 7:00 am to 3:00 pm shift on the 3rd floor and was R2's assigned CNA. V3 stated, "(R2) speaks Spanish and a little English.	S9999		

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(R2) likes to walk around all on the floor. (R2) goes into other resident's rooms. When (R2) does, I (V3) do redirection." When asked if R2 responds to the redirection, V3 stated, "Sometimes redirection don't work." V3 stated, the 3rd floor is not a locked floor, and staff have a code for the stairwell doors when they exit via the stairwell doors. When asked to see the "code" keypad for the stairwell door, V3 walked to the west stairwell door. V3 then demonstrated, that the stairwell door will open by pushing the bar on the door, but then the alarm goes off, and staff must put in the code on the keypad, which V3 performed, to stop the alarm. When asked about R2's elopement from the facility on 6/4/23, V3 stated, "It was around 11:00 am." When asked V3 about seeing R2 prior to 11:00 am on 6/4/23, V3 stated, V3 saw R2 in R2's bed at 7:00 am when V3 started the shift. V3 stated, "(R2) ate (R2's) breakfast. (R2) was already dressed. Wandering, which is constant for (R2). I (V3) would redirect (R2). (R2) was going into other resident's rooms. They (other residents) were frightened. They (other residents) would put on the call light, and they would say, 'There's a (person) in my room.' I (V3) know who they (other residents) were talking about. Then I (V3) would see (R2) and redirect (R2) out of their (other persons') room." When asked about R2's cognitive status on 6/4/23, V3 stated "(R2) was up and alert that morning. (R2) was roaming in other rooms. I (V3) was redirecting (R2), but I (V3) have to clean other patients and am doing my rounds." When asked the last time that V3 saw R2 on 6/4/23, V3 stated, "It was in the hallway, but I (V3) don't know the exact time. When (R2) went missing, I (V3) was in the washroom. I (V3) heard the alarm going off when I (V3) came out of the bathroom walking down the hallway. (V4, Agency RN) or CNA (V5) heard it. They (V4, V5) were saying, 'Where did

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(R2) go?' I (V3) hear the alarm going off, possibly (R2) could have closed it (the west stairwell door). I (V3) then went down the stairs (west stairwell) and didn't see (R2). I (V3) asked (V21, Receptionist), and (V21) didn't see (R2). I (V3) thought that maybe (R2's) still here, so I went out the back door to the parking lot. I (V3) didn't see (R2). I (V3) came back to the floor, and we (staff) searched all the rooms and in empty room, room 314." When asked how is V3 ensuring that a resident who wanders, like R2, is safely supervised, V3 stated, "For me (V3) personally, I know (R2) likes to walk. I (V3) let (R2) walk. (R2) doesn't like being in (R2's) room. I (V3) let (R2) walk sometimes and give (R2) a cookie if (R2) goes into someone's room. I (V3) have rounds to do. I (V3) have other patients to care for." V3 stated, "Sometimes (R2's) confused" and V3 gives R2 "verbal cues" if R2 needs it."

R2's Progress Notes, on 6/4/23 at 2:48 pm, V4 (Agency RN) documents, in part, "11:05 am: (R2) walked up to (V4) to get (R2's) scheduled medication. 11:10 am: It was reported that (R2) was no longer in (R2's) room. Room search was done on the facility and a code was called. (R2) was still not found. (V1) was called and the security camera reviewed that (R2) left through the back door."

On 6/7/23 at 4:00 pm, V4 (Agency RN) stated, V4 works frequently at the facility as an agency nurse, and V4 stated, on 6/4/23, V4 worked the 7:00 am to 3:00 pm shift on R2's floor (3rd floor). When asked about R2 on 6/4/23 at beginning of V4's shift, V4 stated, "I (V4) saw (R2) standing by (R2) room. (R2) stood there. I (V4) said, 'Hi, I am your nurse. I am going to be giving you your meds.' (R2) said (R2) wanted to go pee in the staff bathroom. I (V4) told (R2) there is a

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bathroom in (R2's) room; pointing to (R2's) room." V4 stated, the staff bathroom is not open for R2 to use. V4 stated, "I (V4) told the CNAs (V4 and V5, Agency CNA) to pay attention to (R2)." V4 stated, "(R2) looked confused." V4 stated, "Sometimes, I (V4) did not understand (R2). (R2) would go to elevator. (R2) always asking for (R2's) insurance money. (R2) needs (R2's) money. (R2) needs to go get it. At the moment, I (V4) didn't understand. I (V4) then put 2 and 2 together." V4 stated, R2 was making these statement about getting R2's money on 6/4/23 prior to eloping from the facility. When asked if R2 had spoken about getting R2's money prior to 6/4/23, V4 stated, "On other occasions, (R2) had talked about getting money from somewhere." When asked if R2 would give specifics about where R2 was wanting to go to get R2's money, V4 stated, "No location. (R2) would point to elevator to go down." V4 stated, V4 "never see him get in the elevator," but R2 would "stand next (to the) elevator" and did not get in the elevator "because (R2) didn't recognize that there was a button." V4 stated, "(R2) has (an) alarm. (R2) never seen that (R2) activated an (electronic monitoring safety device) alarm." V4 stated, "(R2) always had on (electronic monitoring safety device)." Surveyor asked V4 if V4 observed R2's electronic monitoring safety device prior to 6/4/23. V4 stated, "Yes, before June 4th, (R2) had on (electronic monitoring safety device)." Asked what R2 continued to do throughout the morning on 6/4/23. V4 stated, "The next time I (V4) see (R2). I (V4) push my (medication) cart down the hall. I (V4) saw (R2). (R2) says, 'Where's my room?' (R2) came again into another resident's room. I (V4) redirected (R2) to (R2's) room. I (V4) talked to the CNAs (V3, V5) and told them to watch (R2), and it's not appropriate for (R2) to go into another resident's

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room." When asked which room did R2 go into, V4 stated that it was the room opposite, "the room right across the stair door at the (west) end." V4 stated, R2 took one medication from V4. V4 stated, "I (V4) told (R2) (about the medication). (R2) refused. So, I (V4) pushed back and at 11:00 am, (R2) said, (R2) wants (R2's) meds." V4 stated, on 6/4/23 at 11:00 am, V4 stated, "I (V4) asked (R2) why (R2) was wearing a sweater. (R2) said, 'It was cold.' Then in a 5-to-7-minute time (frame), it was 'Where was (R2) '?'" V4 stated, "(R2) was not in (R2's) room. Oh, okay. I (V4) felt like (R2) was confused. I (V4) told CNAs (V3, V5) to focus on (R2) all the time. 'You need to pay attention.' Redirect as much as possible. (R2) listens. It's a different story if (R2) doesn't listen. No pacing. (R2) was just walking." When asked where was V4 at 11:07 am on 6/4/23, V4 stated, "Then I (V4) was at nurse's station at the med cart. I (V4) had to do (blood sugar checks) and had the paper and was checking from the (medication) cart; from the people (residents) and marking through the names. I (V4) checked my list. Then (R2) walked behind me." V4 stated, "5 minutes later. I (V4) turned to (V15, Housekeeper) 'Where's (R2)?' (V15) said, 'Where is (R2)?' I (V4) said let's check the bathroom. Nobody. We opened all the bathrooms." V4 stated, "First thing, (R2) was walking close to the stairs. Maybe (R2) went through. That was by the original bathroom (R2) was trying to get into." V4 stated, "We checked all resident rooms." When asked did V4 hear any alarms on 6/4/23 at 11:07 am, "I (V4) was focusing on it (blood sugar checks). There was like a bed alarm. When a resident moves (with a bed alarm) and it (stairwell alarm) was the same thing. I (V4) look at all the residents. My thinking, it was the alarm. I (V4) was thinking it (stairwell alarm) was a bed alarm." When asked where

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other staff (V3, V5) were at when V4 heard the alarm, V4 stated, "People were looking, moving around, and came back to my station. (V15) was there in front of (R2's) room. CNA (V3) was in the (staff) bathroom. My mind was that (R2) was in the bathroom." V4 stated, V3 (CNA) then went to the 2nd floor. V4 stated, V4 called the 4th floor staff and R2 was not on the 4th floor. V4 stated, "I (V4) called down to reception (V21) for a code (yellow)." V4 stated, "I (V4) did hear (the stairwell) alarm. It wasn't loud, so you can know that someone can pass through. It was like a bed alarm. I (V4) am not familiar with stairs alarm. People don't use the stairs. 'Where is this alarm coming from?'" V4 stated, "CNA (V5) was running with me (V4). We have resident bathroom down there. We were looking. I (V4) called him then, called a code (yellow). (V21, Receptionist) said, 'I didn't see (R2) down there.' I (V4) said, 'Be on the lookout. (R2) didn't go on elevator.'" V4 stated, "I (V4) hear it, (stairwell) alarm, but it's like a bed alarm. You use a code to stop it (stairwell alarm)." V4 stated, "(V3, CNA) was down the stairs then. I guess we (V3, V4) met at reception. We can't find (R2)."

On 6/6/23 at 2:15 pm, V5 (Agency CNA) stated, on 6/4/23 from 7:00 am to 3:00 pm, V5 worked on R2's floor (3rd floor). V5 stated, on 6/4/23 prior to R2's elopement, "I (V5) see (R2). Both in (R2's) room and hallway. At the beginning, (R2) was in other resident rooms. I (V5) was assisting (R2) back to (R2's) room. I would redirect (R2) saying, 'Hey, let's go back to your room. You are in someone else's room.' (R2) didn't speak much English. (R2) speaking back in Spanish. I (V5) escorted (R2) in (R2's) room for a while then (R2) came back out. I (V5) was at nurse's station. (V4) asked me (V5) by the stairs (about R2's location). I (V5) didn't see (R2) walk out it (stairwell door)."

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zipper in front. Put zipper on. (V4) turned. (V4) asked (R2) 'Why (R2's) wearing jacket? It's hot here.' R2 said, '(R2's) cold.' That's when (R2) was coming out of (R2's) room to the nurse's station. (V4) was standing by nurses' station at (medication) cart. In front of cart. One CNA (V5). I (V15) don't remember where other CNA (V3) came from." When asked if V15 heard any alarms, V15 stated, "No, I (V15) didn't hear any alarm from the stairs."

On 6/12/23 at 11:00 am, V21 (Receptionist) stated, V21 worked from 8:30 am to 9:00 pm on 6/4/23 at the receptionist station at the desk in the front lobby of the facility. V21 stated, as part of V21's responsibilities, the video footage images are "monitored by us (receptionists)" of each screening area in the facility including the back door on the 1st floor. When asked about the 1st floor back door alarm, V21 stated, "We are also monitoring. They (visitors) must ring doorbell. Back door visitors must be buzzed in 24 (hours)/7 (days a week). Workers or employees will use code for entry. Visitors must be buzzed in." When asked if V21 is sitting at the receptionist desk in the front lobby, can V21 visually see the back door, and V21 stated, "Sitting there physically. I (V21) can see normally down the hallway. I (V21) can see that door." When asked would V21 be able to see someone leaving the facility via the back door, V21 stated, "It depends. I (V21) can see. I (V21) can't make there person out. I could make out body stance. There are 3 racks with towels. When those (racks) are there, they are blocking. (They're) not all the way blocking the (back) door. It's iffy, I (V21) can't see. I (V21) can't make them (person exiting back door) out." When asked if the blue laundry bins (racks) are in the 1st floor hallway on the wall, can V21 physically see a person exiting at the back door

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without the video camera screen, and V21 stated, "No, not really." When asked how would V21 be able to see the person leaving out the back door then, V21 stated, "Camera." V21 stated, it's not a clear picture of individuals with seeing the "back of their head" since the video camera is positioned from the "hallway view outward." When asked if there is an alarm system on facility 1st floor doors, V21 stated, "Yes. They (front and back doors) both do." V21 stated, the 1st floor front and back doors are equipped with an electronic monitoring safety device alarm, and when a resident with an electronic monitoring safety device gets near the front and back doors, the alarm would be activated. V21 stated, "I (V21) would hear 'beep and beep' as I am sitting there at desk." V21 stated, when the 1st floor back door alarm is triggered, V21 would hear the alarm noise at the back door location. When asked if V21 can hear the 1st floor back door electronic monitoring safety device alarm, V21 stated, "I (V21) would have to be listening. If they (the resident with an electronic monitoring safety device) got out. I (V21) would hear beep, beep. I (V21) would see on the camera and see if there is an individual. A resident or something that would have caused the issue. I (V21) physically go down (to the back door) and disarm the alarm." When asked how the alarm is disarmed, V21 stated, V21 puts in a number code, and "it (alarm) will fade out and go away." V21 stated, "It will continue to beep until you disarm it." When asked if V21 knew R2 prior to R2's elopement on 6/4/23, V21 stated, "Yes" that it was when R2 was first admitted to the facility (R2's admission date is 5/13/23). When asked if V21 would be able to visually recognize R2 in physical appearance, V21 stated, "Yes." V21 stated, "On 6/4/23, it was a typical morning. Around 11:00 am something. I (V21) can't recall exact time. I (V21) got a call

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from (V4), asking if I knew where abouts of R2. I (V21) told (V4) that I (V21) haven't seen (R2). I (V21) asked 'What happened?' (V4) said, (V4) don't see (R2) in (R2's) room. I (V21) told (V4) that I (V21) never saw (R2) come down the front or side elevators. I (V21) am thinking if (R2) came down the stairs, I (V21) could see the back of (R2). But how did (R2) get downstairs? I (V21) told (V4) if you are not seeing (R2), I (V21) will call code yellow. After (V4) confirmed, I (V21) got on overhead page. When asked where was V21 at 11:08 am on 6/4/23, V21 stated, "I (V21) was at the receptionist desk, speaking to (R13) in a wheelchair." When asked where was R13 positioned when V21 was conversing with R13, V21 stated, R13 was "kitty corner (diagonal) on my right side, and I (V21) am facing the middle elevator." V21 stated, from the back area (on 1st floor), R2 did not come towards the receptionist desk, "Not at all. V21 stated, "never heard anything. Nothing alarmed that someone got out there (back door)." When asked if the back stairwell (west stairwell) is locked on the first floor, V21 stated, "No. Residents can take a stairwell down." When asked if V21 heard an electronic monitoring safety device alarm from the 1st floor back door on 6/4/23 at 11:08 am, V21 stated, "No. Nope." When asked if there were blue laundry bins (racks) in the 1st floor hallway on 6/4/23, V21 stated, "Yes." When asked if V21 saw R2 on the 1st floor back door video camera view on 6/4/23 at 11:08 am, V21 stated, "No. If there was an image, I (V21) wouldn't have known it was (R2). (R2) would have had an (electronic monitoring safety device) on. We have regular employees who walk back there. I (V21) would not be able to make (R2) out."

On 6/14/23 at 2:01 pm, V21 (Receptionist) stated,

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the elopement risk list (residents who are assessed as an elopement risk) is posted at the receptionist's desk in a red binder. V21 stated, V21 checked the elopement risk list on 6/4/23. V21 was asked on 6/4/23, was R2 on the elopement risk. V21 stated, "No, I (V21) don't think so."

On 6/8/23 at 1:42 pm, V18 (Dietary Aide) stated, V18 works in the kitchen and works on the weekends. V18 stated, on 6/4/23, V18 worked from 6:00 am to 2:00 pm. When asked on 6/4/23 at 11:08 am, did V18 see R2 eloping from back door on the 1st floor, and V18 stated, "No, I (V18) don't recall." V18 stated, V18 had met R2 prior to 6/4/23 and V18 would see R2 in R2's bed each time V18 would be picking up meal trays. V18 stated, "I (V18) know (R2's) general appearance. I (V18) would recognize (R2) if I saw (R2)." This surveyor informed V18 that this surveyor and V1 viewed the facility video footage from 6/4/23 when R2 eloped out the 1st floor back door. When asked where V18 was going when V18 was walking down the 1st floor hallway towards the back door direction on 6/4/23 (as observed on the video), V18 stated, "Around that time, I (V18) turned to the laundry or lady's locker room." When asked on 6/4/23 at 11:08 am, did V18 hear alarms at the back door, V18 stated, "No, I (V18) didn't hear anything."

On 6/8/23 at 11:30 am, V16 (Clinical Care Coordinator) stated, V16 was the "manager on duty" or "MOD" on 6/4/23 and arrived "around 9:10 am." V16 stated, one of V16's responsibilities as the MOD is to "use the remote" for the electronic monitoring safety device alarm systems for the 1st floor front and back doors in the facility. V16 stated, V16 "checked the doors" on 6/4/23 around 10:00 am after V16 did V16's

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(V13) placed it on (R2's) right wrist. I (V13) checked it (electronic monitoring safety device) prior to putting it on (R2). We had the old one (from the previous electronic monitoring safety device alarm system). And then I (V13) grabbed a new one. And I (V13) checked it prior. I (V13) used a remote to check it. We can get the remote. It's (remote for electronic monitoring safety device checks) in (V12's, Maintenance Director) office." V13 stated, "I (V13) did see (R2) walking and pacing the hallway." When asked who the nurse was who asked for the electronic monitoring safety device to be placed on R2, V13 stated, "It was the nurse on the floor, the restorative nurse (V14)." When asked if V13 ever tested R2's electronic monitoring safety device after applying it on R2 on 5/16/23, V13 stated, "I (V13) had tested it on another day because I (V13) tested it prior (to putting it on R2)." When asked when this date was, V13 stated, "It was on a really busy for (V11, SSD). (V11) does the updates on Fridays. I (V13) did it that next Friday (5/19/23). It (R2's electronic monitoring safety device) was functioning at that time." V13 was asked to demonstrate the testing method of a resident's electronic monitoring safety device with the remote (present in the conference room on the table), "You turn it on. And the message says good. I (V13) tested it that way with (R2)." V13 stated, V13 performed the elopement risk assessment for R2 on 5/16/23 as part of R2's social services admission assessments and V13 "did (R2's) care plan." When asked about the score of R2's elopement risk assessment, V13 said, "Score, right down here, would be (R2's) score. At risk." V13 stated, V13 fills out all the elopement risk evaluation questions, and the questions that are marked with "yes" totals for the final score. V13 stated, any score above a 4 is a high risk on the elopement risk evaluation. V13

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S9999	Continued From page 22 stated for "at risk" for elopement residents does include behaviors that would be concerning, like "wandering tendency." V13 stated, "(R2) was at risk for elopement. Wandering tendency. Keep eye on (R2). Eye on (R2) and a personal safety alarm device." When asked what the personal safety alarm device (electronic monitoring safety device) is, V13 stated, "It sounds an alarm that someone has gotten in the elevator or gone out one of the doors. Bracelets made to one of those 4 exits. Doors on the main floor and elevators, there's an alarm." V13 stated, "(R2) is oriented to self. Oriented to person and not to situation or what was going on." When asked about testing R2's wander guard other than when V13 stated on 5/16/23 and on 5/19/23, V13 stated, "I (V13) don't recall testing (R2) another time." When asked if V13 informed V11 (SSD) when V13 placed R2's electronic monitoring safety device on R2 on 5/16/23, V11 stated, "I (V13) did not that day. It's one of those things that slipped through the crack." When asked V13 in reference to the elopement risk list, can V13 update the elopement risk list, and V13 stated, "That's (V11, SSD.) I (V13) have not updated it." V13 stated, "For the elopement risk list, they (residents) all have (electronic monitoring safety devices) on them attached." V13 stated, residents who are at risk for elopement are "making statements, consecutively needing to go to the store, saying 'I need to pay my bills.' They have more of an idea or plan. Obsessive thinking with poor cognition. They have it in their mind that 'I have to do it.'" V13 stated, "(R2) was pacing, walking into rooms. Now (R2) has 1:1 sitter." V13 stated with R2's electronic monitoring safety device, "(R2's) on the list now. That's how staff are able to know who an elopement risk is." V13 stated, on 5/16/23 when V13 applied R2's electronic monitoring safety device, "I (V13) did not document the device	S9999		

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S9999	Continued From page 23 number or mode. I (V13) was unaware that we needed to document it." On 6/8/23 at 3:39 pm, V13 (Social Worker) asked if she checked the functioning of the electronic monitoring safety device on 5/16/23 after placing it on R2. V13 stated, "Since I (V13) checked it right before, I didn't check after putting on (R2)." V13 asked if V13 completed electronic monitoring safety device inventory log. V13 stated, "(V11) does the (electronic monitoring safety device) log. Not me. So, no." R2's Elopement Risk Evaluation, dated 5/16/23, documents, in part, 8 questions to be completed for the risk score total. V13 performed and documented R2's 5/16/23 Elopement Risk Evaluation and answered "Yes" to the following 3 questions: "The resident has the physical ability to leave the facility," "The resident has a firm desire/intent to leave the facility," and "The resident has attempted or has an actual elopement in the last year." Question #8 ("The resident is confused to time and place and has the physical ability to leave the building?) was not answered Yes or No by V13 (left blank). V13 documented that "all interventions that apply" to R2 is "Personal Safety Alarm Device." On 6/20/23 at 1:58 pm, reviewed the 5/16/23 elopement risk evaluation V13 performed for R2, V13 stated, the answers to the questions determine the risk score. V13 stated, "That's why (R2) had score of 3 because (R2) had 3 yeses." V13 stated, with question #5 "The resident has attempted or has an actual elopement in the last year," V13 documented yes because of R2's wandering. V13 stated, R2 was at 'low risk' with a score of 3. This surveyor then pointed out to V13 that V13 did not answer question #8 "The	S9999		

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S9999	Continued From page 24 resident is confused to time and place and has the physical ability to leave the building?" When asked why did V13 not answer question #8, V13 stated, "It was a mistake." When asked if not answering question #8 on the elopement risk evaluation would change R2's risk score if it's answered, V13 stated, "Yes, it would change (R2's) score. It would have changed (R2's) score to a '4' and put (R2) in the high-risk (elopement risk) category." V13 stated, V13 had alarms that was in place" with R2 being at risk for elopement. On 6/8/23 at 11:00 am, V14 (Restorative Nurse) stated, "I (V14) am the only one (restorative nurse)" in the facility. V14 confirmed, V14 performed the restorative assessment for R2 on 5/16/23. When asked if V14 requested from V13 to have an electronic monitoring safety device to be placed on R2, V14 stated, "I (V14) cannot remember." V14 stated, "If they (residents) need an (electronic monitoring safety device), we coordinate with social services." V14 stated, "(R2) walks around hallways. Due to (R2's) cognitive impairment, (R2) needs to be redirected from time to time." V14 stated, when staff place an electronic monitoring safety device on a resident, social services staff will put the resident on the elopement risk list. V14 stated, the elopement risk list is then placed at the receptionist's desk and the floors' nurse's stations. R2's Care Plan, dated 5/17/23, documents, in part, a focus of "(R2) an elopement risk/wanderer" with a goal of "(R2) will not leave facility unattended" with interventions of "(R2) will be frequently monitored as needed" and "place personal safety alarm and/or (electronic monitoring safety device): (specific device # model) on (specify name/me)."	S9999		

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S9999	Continued From page 25 On 6/7/23 at 11:45 am, V11 (SSD) stated, V13 (Social Worker) is the "social services designee." V11 stated, V11 is not assigned to the 3rd floor residents, and not "super familiar with (R2)," but V11 did see and visit R2 on the 3rd floor when V13 wasn't working. V11 stated, "New admission resident, we do an intake on one of the admission assessments. Elopement low risk or high risk. We look at cognition, dementia, or Alzheimer's diagnoses. If known to wander. Some residents will pace back and forth without wanting to leave. Physically able to leave, and cognition. We look at it all. If there's a case: low risk per the (elopement risk) assessment, based off a number score with 0-3 low risk and 4 and above is high risk. Then update care plan." V11 stated, "High risk means at risk. With a score of 3, resident is still at risk." V11 stated, if the nurse tells V11 that a resident who has "cognition severely impaired" tries to get on the elevator or says that they were going "downstairs," V11 would put an electrical monitoring safety device on the resident. V11 stated, "I (V11) would test the (electrical monitoring safety device) bracelet. When I (V11) first got it on. And I (V11) tested all the (electrical monitoring safety devices) on Fridays. I (V11) have been doing it for around 2 months ago. (V12, Maintenance Director) gave me training." When asked if V11 did the electrical monitoring safety device testing on 6/2/23 (Friday) of all residents wearing the electrical monitoring safety devices, "Yes." When asked on 6/2/23, did V11 test R2, and V11 stated, "I (V11) don't recall. If (R2) had one. Yes. (R2) did." When asked who is responsible for the elopement risk list, V11 stated, "I (V11) create the list. I (V11) update it every Friday. Or if there's an elopement attempt or a new admission then I update it." This surveyor and V11 viewed the elopement risk list, updated	S9999		

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S9999	Continued From page 26 on 6/5/23, and V11 stated, "Elopement for R2 (on 6/4/23). So, I (V11) updated it. There are 7 copies. One at Receptionist. And at nurse's station. In cabinet (is the) elopement list in a binder. One on each floor. I (V11) add any resident." When asked since V11 updates the elopement risk list every Friday, so for the 6/2/23 elopement risk list, was R2's name and picture on the list? V11 then looked at R2's (electronic medical record, EMR) profile picture, confirming R2's identity. When asked again if R2 was on the 6/2/23 elopement risk list, V11 stated, "I (V11) don't believe so. I (V11) don't think he was on the list." V11 stated, "On 6/5/23 after R2 eloped. I (V11) tested (R2)." This surveyor questioned V11's previous statement about testing R2 on 6/2/23, V11 stated, "If (R2) was not on the list, I (V11) would not have tested (R2). I (V11) don't think (R2) was on it." V11 then checked on V11's laptop computer during the interview and viewed previous elopement risk lists. V11 stated, "(R2) was not on the (elopement risk) list on 6/2/23. I (V11) didn't not test (R2). I (V11) do apologize." This surveyor and V11 next viewed the copies of the elopement risk lists from May 12, May 19, May 26, and June 2, 2023. V11 stated, "I (V11) update it once a week and as needed" and confirmed that V11 updated the elopement risk list on the May and June 2023 dates. V11 stated, V11 added R2 on the elopement risk list on 6/5/23, only after R2's elopement from the facility. V11 stated, the elopement risk evaluation and care plan are updated for elopement risk list residents. V11 stated, "(Electronic monitoring safety device) residents at risk are on (elopement risk) list with updated pictures. Updated pictures as much as I (V11) can." When asked why would V11 want an update picture posted of an elopement risk resident, V11 stated, "Pictures that's all they (staff) have if they (residents) are	S9999		

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not here. To have a current picture of them (residents). Pictures taken upon admission, so in an emergency, nurse can verify." V11 stated, "My responsibility is for those residents that are on the list, are on the (elopement risk) list. As social service director, I (V11) must know, and so does (V13) and vice versa. I (V11) am responsible for it."

On 6/8/23 at 3:15 pm, when asked prior to 6/4/23, had V11 (SSD) checked the functioning of R2's electronic monitoring safety device(s), V11 stated, "I (V11) did not know it was on (R2), so the answer is no. I (R2) did not check." V11 stated, V12 (Maintenance Director) trained V11 on how to use the remote and "gave me the code." V11 stated, "I (V11) see as a result, and it beeps for sure. It says good/okay to indicate that it is functioning." V11 stated, "If it doesn't say that, then report to V1 and V12." V11 stated, V11 will get the electronic monitoring safety devices and bracelet bands from V12. V11 stated, V11 looks at the back of electronic monitoring safety device for the expiration date and the serial number, and V11 will document this information on the inventory log. When asked who access to the electronic monitoring safety device inventory log would have, V11 stated, V1 (Administrator) or V2 (DON) have access to it. V11 stated, when V11 updates the elopement risk list, V11 will update the electronic monitoring safety device inventory log. V11 stated, "(Electronic monitoring safety device) inventory list is the same as the ones on the elopement risk. Yes, right."

Facility document titled "Elopement Risk List" and updated on 5/12/23, 5/19/23, 5/26/23 and 6/2/23, does not document R2's name, floor, room number or picture. All these updated "Elopement Risk List(s)" document, in part, "Please monitor

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S9999	Continued From page 28 the following residents every 1-2 hours for wandering behaviors and check for wander guard placement once a shift. Please try to redirect resident if they exhibit wandering behavior. Notify Admin (Administrator), DON, and Social Services immediately of any of these residents attempt to get on an elevator or leave the building unsupervised." Facility undated document titled "(Electronic monitoring safety device) Inventory Log" documents, in part, R2's name with an "Issue Date" of "6/4/23" with "Location" of "Right Wrist" with the serial number and expiration date included. On 6/6/23 at 3:49 pm, V7 (Licensed Practical Nurse, LPN) stated that V7 was working on the 2nd floor on 6/4/23 for the evening and night shifts and that "after 9:00 pm," V7 received a phone call from a person (V48) who stated that V48 was the family member of V24 (R2's Friend). V7 stated that V48 was calling from out of the state on behalf of V24 to inform the facility that R2 was at V24's apartment. V7 stated that V7 obtained V24's phone number and V48's phone number, and then called V19 (LPN) who was the 3rd floor nurse to relay this information. V7 stated that at this time, it was change of shift and that V6 (RN) was starting the 11:00 pm to 7:00 pm shift. V7 stated that when a resident has an electronic monitoring safety device, V7 will document the placement of the device on the resident's MAR (Medication Administration Record) or TAR (Treatment Administration Record) by placing a "yes" or "no." V7 stated that if the 1st floor back door alarms for the electronic monitoring safety device, it will alarm on the 2nd floor at the nurse's station. V7 stated that there's a button at the 2nd floor nurse's station that can be used when the	S9999		

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electronic monitoring safety device alarm is triggered on the 1st floor back door, but V7 goes to see why the alarm is triggered. V7 stated, "I (V7) physically go off floor. They (alarms) are not humans. Staff is backup to know that someone is gone. I physically go and see if someone is gone. Can't count on that alarm. When we assume, you know it hits the fan. We are educated now."

On 6/8/23 at 11:58 am, V19 (LPN) stated that on 6/4/23, for the day shift from 7:00 am to 3:00 pm, V19 worked as the wound care treatment nurse, and then on 6/4/23, from 3:00 pm to 11:00 pm, V19 was the primary nurse on the 3rd floor. V19 stated that V19 had been R2's nurse prior to 6/4/23. V19 stated, "(R2) is a little bit confused on and off. Sometimes in bed. Sometime will walk around on the floor. (R2) would walk outside (R2's) room, and I keep watching (R2). Redirect (R2). Especially after dinner, redirect (R2) to go back to bed. Say 'It's time for bedtime.' (R2) would complaint and say, 'Why do I (R2) have to go back?' (R2) would speak in Spanish and understands English. Sometimes (R2) talks a mix of English and Spanish." V19 stated, "(R2) would walk the halls and into the other residents' rooms. We must tell (R2) 'That's not your room' and sometimes, (R2) would walk out and try to find a bathroom. I (V19) would say 'Your bathroom is inside your room.'" When asked if R2 was an elopement risk, "(R2's) not. He's a wanderer. (R2) would say that (R2) wants to get (R2's) check. That's what the CNA told me (V19). (R2) said that it's a bank on Pulaski." V19 stated that R2 had on two electronic monitoring safety devices, one on wrist and one on ankle. V19 stated that when R2 was wandering the floors, V19 would "grab (R2) and patients will be calling us (staff) that (R2) is in this room. We (staff) keep eye on (R2)." When asked how does V19 know who an elopement

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risk resident is, V19 stated, "There's a sign. A paper of elopement risk (residents) in a book and at front desk. If I (V19) am on the floor, I will get it in nurse report. So, we will know. Or social services will come and in-service us. It is responsibility for the nurse to check the book." When asked if residents who are on the elopement risk list have electronic monitoring safety device, V19 stated, "Yes." V19 stated, "The first time I (V19) heard (R2) was located was at end of shift 3:00 pm to 11:00 pm shift. From (V7) on the 2nd floor. (V7) said, 'You have a missing (resident)?' (V7) was like someone called (V48 who is V24's Family Member) and said that (R2) was (V24's) house. This was around 11:30 pm." V19 stated that V19 finished giving report to V6 (RN), and then went downstairs to the 2nd floor to call V48 who provided V7 with V24's address where R2 was at. V19 stated that V48 informed V7 that V24 wanted R2 to be picked up from V24's apartment (which is 4 miles away from the facility). V19 stated that V19 called V2 (DON), V44 (R2's Family Member) and the local police department. V19 stated V19 then drove in V19's car to V47's apartment address after 1:00 am and waited for the local police department to arrive. V19 stated that V19 saw the police officers get "access into the (apartment) building when (V24) gave them (police officers) the key through the window from the 3rd floor with a string on a key. They (police officers) were in there for a while. They (police officers) come out with (R2)." V19 stated that the local police department officers assessed R2 to bring R2 back to the facility.

In R2's Progress Notes, on 6/4/23 at 10:21 pm, V19 (LPN) documents, "(R2) was unavailable."

On 6/13/23 at 12:37 pm, V24 (R2's Friend) stated that on 6/4/23, V24 stated, "(R2) come here after

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S9999	Continued From page 31 11 (am). Someone opened the door for (R2). I (V24) think they thought that (R2) used to live here. But (R2) didn't." When asked did R2 say how R2 got to V24's apartment (4 miles from the facility), V24 stated, "(R2) said the police had brought (R2). Then (R2) said that (R2) got a ride from somebody. And (R2) walked. (R2) told me 3 stories." When asked what condition was R2 in when R2 arrived on 6/4/23, V24 stated, "(R2) no walk better. (R2) slow and tired." V24 stated that V24 had been talking to V47 on the phone while R2 was present on 6/4/23. V24 stated that V24 had then called V44 (R2's Family Member) to find out that R2 was living in a nursing home, which V24 did not know, and that is why V48 (V24's Family Member) then phoned the facility staff. V24 verified V24's address. When asked what kind of street is Diversey that V24 lives on, V24 stated "It's a very busy street. There's all the time cars driving so fast." V24 stated that V24 was "scared for (R2)" and that V24 didn't want to leave R2 alone because V24 has 2 doors, and R2 could go out the back door if V24 left R2 alone. V24 said that when police arrived, V24 put the key down outside the window down to the police. When asked what was R2's cognition on 6/4/23, V24 stated, "(R2) is very confused. All the time." On 6/7/23 at 2:31 pm, V6 (RN) stated that V6 worked on the 3rd floor from 11:00 pm to 7:00 am on 6/4/23. When asked if electronic monitoring safety device residents would be on the elopement risk list, V6 stated, "Yes. (Electronic monitoring safety device) residents would be on the list. It shows all floors." V6 stated that on 6/4/23, "(R2) has one on right wrist and left ankle. We do checks (of electronic monitoring safety device) on our shift. It's not reflected in the MAR, but we check on that also."	S9999		

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S9999	Continued From page 32 V6 stated when V6 started V6's 11:00 pm to 7:00 am shift on 6/4/23, R2 was still not in the facility. V6 stated, "(R2) came back at 2:30 pm. When (R2) came up the elevator with (V7) who let them in. They (R2 and 2 police officers) came into the floor. 2 (local police department) officers were there. We facilitated (R2) to (R2's) room. I (V6) did body check with (V35, CNA)." V6 stated that V6 and V35 then switched off with monitoring R2 as a 1:1 sitter for the remainder of the night shift. When this surveyor read V6 an authored note to V6, this surveyor asked V6 about the "old bluish discolorations to bilateral forearms" for R2. V6 stated, "They were old discolorations. When you see skin be older, turning yellowish." But when questioned about V6 documenting "bluish" color, V6 stated, "Older, skin that's fragile. Discoloration. I (V6) asked (R2) about it. There was no pain. It was nothing new. No break in skin." When this surveyor read V6 another authored note by V6, this surveyor asked V6 about this documentation of notifying V12 (Maintenance Director). V6 stated, "I (V6) informed (V12) to test everything. I (V6) think (V12) is the one for the alarms. Stairwell doors wasn't working enough, or the volume is not high enough for the staff to hear." V6 stated, "I (V6) know (V12's) in charge. I (V6) called (V12). I (V6) let (V12) know right away. I (V6) called (V12) that morning. (V12) said that (V12) will check on it. Check on volume to make sure that everyone can hear, that may be why (R2) left. Daytime, there's lots of noise, maybe staff did not hear." In R2's Progress Notes, on 6/5/23 at 2:54 am, V6 (Registered Nurse, RN) documents, in part, "11:11 pm - (R2) still out of facility; 1:50 am - Per (V2, Director of Nursing, DON), (R2) is on (R2's) will way back to facility C/O (care of) (local police department); 2:20 am - (V1) aware (R2) is back in	S9999		

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the facility; 2:30 pm - (R2) brought back to 3rd floor by 2 (local police department) officers, (R2) alert & verbally responsive, speaks Spanish & with little English ... complete body check done by (V6) & (V35, CNA). No skin breakdown. Noted w/ (with) old bluish discolorations on both forearms."

In R2's Progress Notes, on 6/5/23 at 6:56 am, V6 documents, "(V12) (Maintenance) informed to check elevators (electronic monitoring safety device) alarms & stairwells alarms including alarm volumes."

On 6/6/23 at 1:40 pm, V12 (Maintenance Director) and this surveyor performed an initial environmental tour of the facility. V12 stated, on the 1st floor, the back door electronic monitoring safety device alarm gets triggered when a resident walks through the back door wearing an electronic monitoring safety device. V12 stated, the electronic monitoring safety device alarm goes off on the second floor with the announcement of where the electronic monitoring safety device alarm is being triggered. V12 stated, "There is a noise that comes from the back door when the alarm is going off." V12 and this surveyor were near the back door while V12 was holding a electronic monitoring safety device as V12 walks towards the back door, and the back door electronic monitoring safety device alarm goes off with loud beeping alarm. V12 then puts in a code on the keypad at that back door to silence the electronic monitoring safety device alarm. V12 stated, "You have to put in the code to silence the alarm." When asked V12 how far before a resident reaches the back door before the electronic monitoring safety device on the resident will trigger the alarm, V12 stated "About 10 feet to the door." V12 stated, electronic

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monitoring safety devices can be placed on residents by their hands (wrists) or by the foot (ankle), and the electronic monitoring safety device would trigger the door alarm. When asked how on 6/4/23, R2 eloped out the back door of the facility with electronic monitoring safety devices, V12 stated, "I (V12) couldn't explain it. It should have gone off. To trigger it (the back door electronic monitoring safety device alarm)." V12 and this surveyor then went to the 2nd floor. V12 showed this surveyor at the 2nd floor nurse's station a panel with labeled buttons. V12 points to the "back door" button and stated, the back door electronic monitoring safety device alarm would trigger here, and it can be "silenced here."
When asked to view the stairwell doors on the 2nd floor, V12 stated, the 2nd floor stairwells (east and west) have a "magnet lock for 15 seconds" when the door is pushed to attempt to open. V12 stated, the 3rd and 4th floor stairwell doors do not have the magnet lock. This surveyor and V12 then went to the 3rd floor. V12 stated, when a resident (with or without an electronic monitoring safety device) would "push the bar" to be able to open the door of either stairwell, the alarm goes off at the door of the stairwell. V12 and this surveyor walked down the hallway on the 3rd floor to the west stairwell (the one that R2 eloped out from on 6/4/23). V12 demonstrated opening the west stairwell door, and the west stairwell door alarm was immediately triggered with loud alarm coming from the door. V12 stated, when V12 had tested the west stairwell daily on the 3rd floor, the alarm was triggered and would sound when the pushing the bar on the door to exit from the floor into the stairwell. When asked why the facility now has a "louder alarm" on the 3rd floor stairwell doors, V12 stated, "It's louder than the ones we had. Before it (volume of alarm) was less. We are

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S9999	Continued From page 35 installing them (louder alarms) for the (stairwell) doors on the 4th floor too." On 6/7/23 at 10:41 am, V12 (Maintenance Director) performed a second environmental tour of the facility. V12 went to the 4th floor. The 4th floor has east and west stairwell doors, like the 3rd floor. When asked about the stairwell door alarms on the 4th floor, V12 stated, "We are going to change them (4th floor stairwell door alarms) on both sides. Put them in like the one's on the 3rd floor (stairwell doors)." On 6/7/23 at 10:44 am, this surveyor asked for V12 to test the west stairwell door alarm walking to the east end of the hallway (near the main elevator), and V12 opened the west stairwell door to activate the alarm. Could hear the west stairwell door alarm in the east end of the hallway. V12 then silenced the stairwell door alarm by putting the numbers on the keypad. On 6/7/23 at 11:17 am, V12 (Maintenance Director) stated, V12 has a remote for the electronic monitoring safety device alarm system that tests the range of the alarm triggered at the front and back doors and both elevators in the facility, and it also tests the functioning of the electronic monitoring safety device tags (or sensors) that the residents wear. V12 stated, V12 checks the stairwell door alarms to ensure that they are working. V12 stated, V12 tests the alarms on the stairwell doors and electronic monitoring safety device alarm system (front and back doors and both elevators) two times a day and keeps a log of this. V12 stated, V12 has had "no issues with the alarms not working" during the daily testing. V12 stated, the managers on duty (MODs) on the weekends are performing the testing of the electronic monitoring safety device alarms and V12 has trained the MODs on how to	S9999		

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use the electronic monitoring safety device remote. V12 stated, the remote will tell if the electronic monitoring safety device on a resident is functioning properly. V12 stated, "whoever is in charge of the departments has been trained" including V11 (Social Services Director). V12 then showed the 4 remote options: "Tag test mode," Tag revision mode," "Check field mode," and "Check RF noise mode." V12 stated, the "Tag test mode" is used to test that the resident's electronic monitoring safety device is working properly.

Facility document dated August 2017 and titled "(Electronic Monitoring Safety Device) User Guide," documents, in part, that for "working in user mode" for the "tag (resident device) test mode," the tag testing procedure in this manual enables the user to "read the tag serial number and test the tag alarm" and to "check the tag battery."

On 6/6/23 at 3:11 pm, V2 (DON) stated, the elopement risk assessment is initiated with social services staff to see if a resident is at risk for elopement. V2 stated, the social services staff member will then let the nurses know about the at-risk elopement assessment. V2 stated, residents who have electronic monitoring safety devices on are placed on elopement risk list, and V11 updates the list every Friday. V2 stated, all staff (nursing staff and other department staff) can see which residents are on the elopement risk list by reviewing the list that is located at each nurse's station. When asked if V2 was present in the facility on 6/4/23 when V2 eloped, V2 stated no, and when V2 came to the facility on 6/5/23, V2 stated, V2 triggered the 3rd floor stairwell door alarms. V2 stated, "I (V2) went all the way to see who would hear it. It sounded more like chair

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alarm. It could have been louder." V2 stated, the 2nd floor is different with a magnet lock to those stairwell doors. V2 stated, V2 was notified via phone by V4 (Agency RN) about R2's elopement on 6/4/23. V2 stated, a code yellow was called and that all staff searched for R2 inside and outside the facility. V2 stated, "late in the evening" on 6/4/23, V2 was informed by V19 (LPN) that R2 was located at V24's apartment, and V2 was able to phone and speak with V24. V2 stated, V2 was in phone contact with V1 (Administrator), the local police department, and V19. V2 stated, V19 was providing V2 updates as V19 went to V24's apartment to ensure that the local police department picked up R2. V2 stated, R2 arrived back to the facility around 2:30 am on 6/5/23. V2 stated, if staff see a resident walking into another resident's room, the staff must redirect the resident back to the resident's room. V2 stated, "(R2) knows where (R2's) room was." When asked if R2 is going into other residents' room and R2 is not responding to redirection, how are staff to respond? V2 stated, staff would redirect R2, have social services meet with R2, or engage R2 in more activities. V2 stated, "I (V2) did not have others report to me that (R2) was going into the residents' rooms. (R2's) the only one on (the 3rd floor) who's on elopement risk list."

R2's Census documents, in part, R2 was moved from the 3rd floor to the 2nd floor on 6/6/23.

On 6/15/23 at 9:17 am, when asked why R2 was moved from the 3rd floor to the 2nd floor on 6/6/23, V2 stated, "We moved (R2) because actually we have the 2nd floor front section to utilize for our fall section. To have another person on monitoring (for R2). Activities, we have more on 2nd floor." V2 stated, the 2nd floor stairwell

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doors are "harder to push out (with a) lock mechanism that you can't go out (for 15 seconds)." When asked if this extra locking mechanism of not being able to exit out of the stairwell for 15 seconds, is the 2nd floor appropriate for elopement risk residents, V2 stated, "Yes, it would be beneficial for safety." When asked with R2's elopement risk evaluation, done on 5/16/23 and R2 was identified at risk, why was R2 not moved to the 2nd floor, and V2 stated, "That could have been beneficial (for R2) to be on 2nd floor. 2nd floor of elopement risk (residents), we did decide it to be beneficial compared to 3rd floor." When asked the purpose of the electronic monitoring devices placed on residents' person, V2 stated, "To keep them safe. (Electronic monitoring safety device is) based on assessment, if think to go out building and will alert the staff that someone is going out. Ensure that we can see them and intervene right away. 2nd floor is contained. Locked system mechanism would be a plus too." V2 stated, "I (V2) expect staff to respond and to distinguish the type of alarm. Sound of alarm and specific time. Beeping. Something beeping. Bed alarm. Call light or exit alarm." V2 stated, "I (V2) expect when staff hear an alarm, the end game is to respond promptly and right away. Hear some alarm going off, and I (V2) expect (them) to go and respond to it right away. Everyone." V2 stated, before 6/4/23, social services staff would test the functioning of the electronic monitoring safety devices on residents every Friday. V2 stated, nurses would then document in the MAR that the resident's electronic monitoring safety device is in place. V2 stated, prior to 6/4/23, V2 was looking for a physician order for R2's electronic monitoring safety device. V2 stated, "I (V2) know (R2) has an (electronic monitoring safety device). I (V2) don't have an order." V2 stated, having a

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physician order for the electronic monitoring safety device would "correlate to come onto the MAR." When asked to explain the process for nurse's to document on the placement of a resident's electronic monitoring safety device prior to 6/4/23, V2 stated, social services does the elopement risk assessment; then the nurse on the floor looks at the assessment; next the nurse would order the place a physician's order for the electronic monitoring safety device; and this would then trigger for nurse's to chart in the MAR on the placement of the electronic monitoring safety device. V2 stated, in checking for R2's electronic monitoring safety device nurse documentation in R2's MAR, V2 stated, "I did not see documentation for (R2)." V2 stated, social services staff determines if a resident is fit to leave building without staff supervision by looking at cognition, medical diagnoses, functionality of the resident or history of substance abuse.

On 6/7/23 at 4:00 pm, V4 (Agency RN) stated when asked about R2's documentation of R2's electronic monitoring safety device, V4 stated, "It's on the TAR. Check yes or no."

R2's Medication Administration Record (MAR) for May 2023 shows no documentation for checks of R2's electronic monitoring safety device. R2's electronic monitoring safety device was initiated on 5/16/23 by V13. R2's MAR for June 2023 documents, in part, that R2's electronic monitoring safety device checks started on 6/6/23.

R2's Order Summary Report, dated 6/6/23, documents, in part, active orders with start dates of 6/5/23: "Check (electronic monitoring safety device) daily to ensure the device is functioning properly, everyday shift for monitoring" and

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"Check (electronic monitoring safety device) to ensure device is in place, every shift for monitoring." R2 eloped from the facility while wearing two electronic monitoring safety devices on 6/4/23.

On R2's Community Survival Skills Evaluation, dated 5/17/23, V13 documents, in part, for question 1. "The residents is sufficiently alert, oriented, coherent, knowledgeable and with good decision-making skills allowing him/her to be considered for independent outside pass privileges," the answer marked is "No."

On 6/6/23 at 11:30 am, when V8 (LPN) was asked if R2 is assessed as a wanderer, V8 stated, "No." V8 stated, R2 oriented x 3 and sometimes oriented to only R2's self. V8 stated, R2 walks with a "little unsteady gait" and V8 will redirect (R2) and walk (R2) back to (R2's) room. V8 stated, V8 was not working on 6/4/23, but V8 was aware R2 eloped from the facility that morning. V8 stated, "We are monitoring (R2). (R2) has a sitter now. With only 2 CNAs for 24 residents and with both CNAs doing care, sometimes we (staff) cannot watch (R2). (R2) has a 1:1 (sitter) now."

On 6/6/23 at 12:32 pm, V11 (Administrator) stated, V1 received a phone call from the manager on duty (V16, Clinical Care Coordinator) on 6/4/23 at 11:36 am that staff did not see R2 on the 3rd floor. V1 stated, V16 informed V1 staff had checked the 3rd floor and the building, and V1 instructed them to call a code yellow. V1 stated, "Code Yellow is when a resident is missing or cannot be accounted for." V1 stated, an immediate search of the interior of the building is done, then an external search of building with staff searching on foot and in cars. V1 stated, V1

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called 911 (not recalling the exact time on 6/4/23), but "they (local police department officers) responded at 1:23 pm in the building." V1 stated, V1 had checked the facility's video camera footage as part of R2's search. V1 stated, "I (V1) saw (R2) left out the back door. (R2) was walking up and down the 3rd floor hallway. Typical for (R2). (V5, Agency CNA) at (3rd floor) nurse's station. (V3, CNA) in the bathroom. (V4, Agency RN) was looking at the medication cart. (R2) left out the back staircase. Camera view on first floor, (R2) went out the back door." V1 stated, "3rd floor (stairwell) door, there is a key code. (It's) not locked. When (stairwell) door opened is alarm, (staff) put key code in. Hear alarm on both sides of (stairwell) door. Back door (on 1st floor) has a (electronic monitoring safety device) alarm. (R2) did have (electronic monitoring safety device) at that time. It did not alarm. Alarm on the 2nd floor for the door (R2's) exiting didn't alarm. The back door, no staff reported that it was going off. On 2nd floor, I was able to watch 2 nurses (via video camera footage), no alarm when off." V1 stated the prior to 6/6/23, "(Electronic monitoring safety device) alarm (on 1st floor back door), it goes off on its own after a certain amount of time. Which was corrected this morning. When it's triggered, it would alarm for 30 seconds then stop alarming. The electric company came today. Now (staff) put in a code on (keypad) panel to stop it." V1 stated, on 6/4/23, staff on the 2nd floor and "people near" the back door didn't hear the electronic monitoring safety device alarm when R2 eloped at 11:08 am. When asked how facility staff can keep residents who are wanders present and safe in the facility, V1 stated, "So when a resident comes in, part of the social services elopement assessment, look for at risk and 1 to 2 weeks, nursing and social services monitor and see if (residents) have the monitoring for wandering

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tendencies. (Electronic monitoring safety device) to keep them safe. Doors would trigger, staff then get to them. Staff know the residents who are at risk and list is done weekly by (V11, SSD)."

Facility document, titled "Draft Interviews" and provided on 6/6/23, V1 documents, in part, staff interviews with V3, V4, V7, V15, V17, V19, V21, and V36 (CNA). V1 documents, in part, for V4 (Agency LPN), "(V4) stated during the morning, (R2) was just wandering around the hall. (R2) did not have any attempts to leave. (V4) was watching (R2) closely because (R2) did say (R2) wanted to get (R2's) check. At one point, (R2) put (R2's) jacket on but stated (R2) was just cold and (R2) was not going to leave." V1 documents, in part, for V3 (CNA), "(V3) stated (R2) was walking the halls in the morning and (V3) redirected (R2) into (R2's) room several times. (V3) stated (V3) was in the restroom and when (V3) came out within a few seconds, (V3) noticed (R2) was gone. Earlier in the morning (R2) told (V3) (R2) had to get to North and Pulaski to get (R2's) check. They (staff) searched the floor and (R2) was not located." V1 documents, in part, for V15 (Housekeeping), "(V15) confirmed (V15) saw (R2) several times throughout the morning while cleaning and was in (R2's) room while (V15) was doing (V15's) daily clean. (V15) went into another room for a brief moment and altered (alerted) (V4) and CNA who were also in the hall." V1 documents, in part, for V17 (Agency RN), "(V17) was at the second-floor nurse's station at the time (R2) exited the building. (V17) confirmed the alarm at the nurse's station did not trigger at this time."

Local police department's missing person's report for R2, dated 6/4/23 at 1:15 pm, documents, in part, R2 was "last seen" on 6/4/23 at 11:08 am

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S9999	Continued From page 43 with the facility's address listed as R2's home address, and R2's age group marked as "over 20." On 6/21/23 at 10:42 am, when asked if V37 (Medical Director) is familiar with R2, V37 stated, V37 did speak with V1 about R2. When asked what V37 knows about R2, V37 stated, R2 has dementia, eloped from the facility, and was returned to the facility. Was explained to V37 that R2 was admitted on 5/13/23; R2 had a social services assessment done for elopement showing R2 was at risk on 5/16/23 when an electronic monitoring safety device was applied on R2; R2 was wandering on the floor and into other residents' rooms; and R2 has a BIMS score of 2. When asked what is V37's expectation of the facility staff in providing supervision to prevent R2 from leaving the facility, V37 stated, "To have a closer eye on (R2). To keep (R2) near the nurse's station. They are changing the alarms at the doors and the abatement plan reflects that, so it doesn't happen again." Was explained the 3rd floor stairwell doors have an alarm that's activated when either a resident or staff push open the door, but then staff can put in a code on the keypad to stop the alarm. When asked what is V37's expectation of facility staff when they hear the stairwell door alarming by R2 pushing open the stairwell door, "Absolutely to respond right away and aide (R2) to redirect (R2) back to the nurse's station or to engage in activities with (R2). Respond right away." When asked what possible affect can R2 have as a cognitively impaired resident eloping from the facility without staff supervision and traveling 4 miles, via an unknown method, into the city community, V37 stated, "It is definitely traumatic. In someone who doesn't know where to go, what to do or how to navigate, it was not a good situation for (R2) to be	S9999		

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in. (R2) probably doesn't remember. (R2) might have been scared."

Daily Nursing Schedules, dated 6/4/23, documents, in part, the following staff were working in the facility from 7:00 am to 3:00 pm on 6/4/23: 2nd floor: V17 (Agency RN), V47 (Agency RN), V22 (CNA), V23 (CNA), V27 (Former CNA); and 3rd floor: V4 (Agency RN), V3 (CNA), V5 (Agency CNA).

On 6/13/23 at 10:52 am, when asked if there are electronic monitoring safety device alarms for the 1st floor back door on the 2nd floor, V23 stated, "Yes. There's an alarm at the nurse's station." When asked if an electronic monitoring safety device resident would trigger the 1st floor back door, V23 stated, the electronic monitoring safety device alarm at 2nd floor nurse's station "triggers the alarm over. Everyone can hear it, even with closed doors, you will hear." V23 stated, V23 would first check the reason why the alarm was going off and then cancel it. When asked how the electronic monitoring safety device alarm at the 2nd floor nurse's station is to be cancelled, V23 stated, "We turn it off. Press a button." V23 stated, staff cancel the 1st floor back door alarm when they make sure "what's going on and check all the rooms." When asked if the alarm is coming from the back door on the 1st floor and is alarming at the panel on the 2nd floor nurse's station, how does V23 check the electronic monitoring safety device alarm? V23 stated, V23 will "go down quickly" to check on the 1st floor, and the alarm will still be going off. When asked if there is a video camera at the 2nd floor nurse's station, "Yes." V23 stated, you can tell who shows up at the back door. When asked on 6/4/23 at 11:08 am (when R2 eloped via the 1st floor back door), did V23 hear the electronic monitoring

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safety device alarm at the 2nd floor nurse's station? V23 stated, "I was in a room giving patient care. In the middle." When V23 already stated, V23 could hear the electronic monitoring safety device alarm with doors closed, V23 stated, "I (V23) was busy, and your mind is settled on what you are doing. I (V23) don't take notice of it." When asked again if V23 heard the electronic monitoring safety device alarm on 6/4/23 at 11:08 am, V23 stated, "I (V23) might have. I (V23) was busy. I (V23) can't remember."

On 6/13/23 at 10:43 am, when asked if on 6/4/23 at 11:08 am, did V22 (CNA) hear an alarm at the 2nd floor nurse's station for the electronic monitoring safety device alarm for the back door on the 1st floor, V22 stated, "I (V22) was doing patient care. I (V22) couldn't hear anything. I (V22) close my door for resident's privacy."

On 6/14/23 at 10:30 am, when asked on 6/4/23 at 11:08 am, did V27 (Former CNA) hear the 1st floor back door's electronic monitoring safety device alarm go off at the 2nd floor nurse's station, V27 stated, "I (V27) can't recall." V27 stated, V27 was a new employee and was not familiar with the alarm sounds in the facility.

On 6/8/23 at 1:55 pm, V17 (Agency RN) stated that she had worked previously in the facility before 6/4/23. V17 stated, there is "an alarm system. The whole building alarm system is at the 2nd floor." V17 stated, "You can hear or see people outside and open the back door." V17 stated, "(Electric monitoring safety device) residents on the elopement risk, it (back door alarm) typically goes off to let know what area where the alarm is going off in." When asked where V17 was on 6/4/23 at 11:08 am, V17 stated, "I (V17) can't tell you where I was. 11:00

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am, I (V17) was at nurse's station (on 2nd floor). No alarm. Only thing that ringed was the back door. Waited for back door to opened and then nothing happened until code yellow." When asked if V17 was familiar with R2, V17 stated, "I (V17) have worked with (R2). 2nd day (R2) was admitted. Agitated. Aggressive. Verbal but barely speaks English. Trying to leave room. Pacing hallways. Going into other resident's room. (R2) would be okay for 1 hour then pacing up and down hallway. Keep eye on (R2). Not to fall. (R2 with) frail and gait unsteady."

On 6/13/23 at 1:00 pm, when asked on 6/4/23 at 11:08 am, did V47 (Agency RN) hear the 1st floor back door's electronic monitoring safety device alarm go off at the 2nd floor nurse's station, V25 stated, "No, I (V47) didn't hear any alarm."

Facility policy dated 7/27/22 and titled "Elopement," documents, in part, "Policy Statement: It is the policy of this facility that all residents are 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 so 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 an alarmed door. b. Door alarms placed on facility exits. c. Keypad controlled elevators. d. Resident will be listed in the Elopement Book, which will be located at the reception desk and each nursing station. 2. As

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S9999	Continued From page 47 part of the facility's Preventative Maintenance Program, all doors and elevator keypads will be checked for proper function daily by the Maintenance department/designee. These checks will be documented with date and time completed. 3. Residents with an adult electronic monitoring safety device will be checked every shift to ensure device is in place. 4. Adult electronic monitoring safety device will be checked weekly to ensure the device is functioning properly. 5. At no time shall a door alarm 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. Routine Procedure for Wandering Residents and Prevention of Missing Residents/Elopement: 1. All residents shall be reviewed for safety awareness impairment and elopement/wandering concerns upon admission, readmission, quarterly, significant change in condition and as needed. 2. Residents identified as at risk for elopement/wandering will have a plan of care implemented to address their elopement/wandering behaviors. 3. All residents who are at risk for possible elopement/wandering shall be accompanied by staff or responsible party when leaving the residents unit and/or facility grounds. 4. Residents at risk for elopement shall be identified in the "Elopement Book." The book will have the list of all residents assessed to be at risk for elopement with their name, room number and photo. This book will be located at the receptionist desk and each nursing station. This book will be updated whenever a new resident is added or taken off the list. 5. When a door alarm sounds, staff members shall immediately respond to determine the cause of the alarm. a. The staff person responding to the	S9999		

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alarm will check the outside of the building/vicinity of the area to determine if a resident has exited the building. b. If upon investigation no reason can be found for the sounding of the alarm, the Administrator/D.O.N./designee must be notified. c. A head count will be initiated on all the units and completed accounting of the residents will be given to the Administrator/D.O.N."

Facility policy dated 11/23/22 and titled "Pass Privilege Policy," documents, in part, "Policy: It is the policy of the facility to ensure that residents are safe to have out on pass privileges. Procedure: 1. Within 72 hours upon admission and readmission, the social service department will complete the Community Survival Skills Evaluation to determine if a resident is able to go out in the community safely without an escort."

Facility document titled "Facility Assessment Tool" and dated 9/29/22, documents, in part, that the average daily census for the facility is 70 to 80 residents; that for "Diseases/conditions, physical and cognitive disabilities" that staff are able to care for include residents with diagnoses of "impaired cognition" with "behavior that needs interventions;" that the "general staffing plan" with staff to provide "person-centered/directed care, psycho/social/spiritual support" includes a plan to "identify hazards and risks for residents;" and that the "staff training/education and competencies" are "training topics include but are not limited to the following" of competencies for "elopement."

Facility Floor Plan, undated, documents, in part, the 3rd floor west stairwell door on the south side of the hallway, and the nurse's station is located towards the east side of the building. The 1st floor shows the 1st floor west stairwell door on the south side of the hallway, near the first of two exit

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S9999	Continued From page 49 doors in the direction of the parking lot (west side of the building). Facility job description dated 5/20/22 and titled "Certified Nursing Assistant," documents, in part, "Summary/Objective: In keeping with our organization's goal of improving the lives of the Guests we serve, the Certified Nursing Assistant (CNA) plays a critical role in providing superior customer service and nursing care to all Guests. The CNA safeguards the health, safety, and welfare of all Guests under their care by following applicable laws, regulations, and established nursing policies and procedures. Essential Functions: 7. Must be knowledgeable of individual care plans and support the care planning process by providing supervisors with specific information and observations of the Guest's needs, preferences and report any behavioral changes ... 25. Ensure each Guest received person centered care. 30. Follow established policies and procedures in support of QAPI efforts." Facility job dated 12/1/2019 and titled "LPN Floor Nurse," documents, in part, "Summary/Objective: In keeping with our organization's goal of improving the lives of the Guests we serve, the Licensed Practical Nurse (LPN) plays a critical role in providing superior customer service and nursing care to all Guests and guests. The LPN provides supervision of staff and will safeguard the health, safety, and welfare of all Guests/guests under their care by following applicable laws, regulations, and established nursing policies and procedures. Essential Functions: ... 2. Provides supervision to CNA's and all subordinate staff which includes checking their work to ascertain that assignments have been completed. 9. Responsible for all nursing	S9999		

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S9999	Continued From page 50 care of assigned Guests while on duty. Must notify appropriate persons if there is any significant change in a Guest's condition. 10. Ensure that Guest care plans are being followed and assess each Guest's status in accord with their care plan. 14. Must be knowledgeable of individual care plans and support the care planning process by reporting specific information and observations of the Guest's needs, preferences and report any behavioral changes. 21. Ensure each Guest received person centered care. 29. Follow established policies and procedures in support of QAPI efforts." Facility job dated 12/1/2019 and titled "RN Floor Nurse," documents, in part, "Summary/Objective: In keeping with our organization's goal of improving the lives of the Guests we serve, the Registered Nurse (RN) plays a critical role in providing superior customer service and nursing care to all Guests and guests. The RN provides supervision of staff and will safeguard the health, safety, and welfare of all Guests/guests under their care by following applicable laws, regulations, and established nursing policies and procedures. Essential Functions: 2. Provides supervision to CNA's and all subordinate staff which includes checking their work to ascertain that assignments have been completed. 9. Responsible for all nursing care of assigned Guests while on duty. Must notify appropriate persons if there is any significant change in a Guest's condition. 10. Ensure that Guest care plans are being followed and assess each Guest's status in accord with their care plan. 14. Must be knowledgeable of individual care plans and support the care planning process by reporting specific information and observations of the Guest's needs, preferences and report any behavioral changes. 21. Ensure each Guest	S9999		

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S9999	Continued From page 51 received person centered care. 30. Follow established policies and procedures in support of QAPI efforts." Facility job dated 12/1/2019 and titled "Director of Social Services," documents, in part, "Summary/Objective: In keeping with our organization's goal of improving the lives of the Guests we serve, the Director of Social Services manages the day-to-day operations of the Social Services Department and responsible for the overall administration, coordination and evaluation of the social services function to meet and maintain the mental and psychosocial well-being for each Guest. Essential Functions: 1. Responsible for keeping up-to-date evaluation documentation on each Guest's activities at the facility which complies with Federal, State and Local regulations. 3. Assists with the coordination, intake, admission, and Guest transfer within the facility. 15. Responsible for training and educating staff members. 21. Ensure each Guest receives person centered care." Facility job dated 2/4/2022 and titled "Social Services Designee," documents, in part, "Summary/Objective: In keeping with our organization's goal of improving the lives of the Guests we serve, the Social Worker ensures that the medically related emotional and social needs of the Guests are met and maintained on an individual basis and in accordance with current federal, state and local regulations. Essential Functions: 1. Responsible for keeping up-to-date evaluation documentation on each Guest's activities at the facility which complies with Federal, State and Local regulations. 2. Develops a comprehensive social history and psychosocial assessment that includes the Guest's problems and strengths and preference and implications for	S9999		

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S9999	Continued From page 52 the care plan. 5. Assists with the coordination, intake, admission, and Guest transfer within the facility. 21. Ensure each Guest receives person centered care. 27. Follow established policies and procedures in support of QAPI efforts." (A)	S9999		