STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001028	A. BUILDING: _____ B. WING _____	C 05/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF GODFREY	1623 29 WEST DELMAR GODFREY, IL 62035

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S 000	Initial Comments Complaint Investigation 2343474/IL159164	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.690 a) 300.1210 b) 300.1210 c) 300.1210 d)3) 300.1220 b)3) 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 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care	S9999		

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BRIA OF GODFREY	1623 29 WEST DELMAR GODFREY, IL 62035

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S9999	Continued From page 2	S9999		

plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to provide supervision to prevent elopement for 1 of 9 residents (R3) reviewed for supervision to prevent accidents in the sample of 15. This failure resulted in R3 exiting the facility twice, once found standing next to a busy roadway in the rain, and once found ambulating around a nearby neighborhood. This failure has the potential to not only affect R3, but R2, R4, R7, R8, R9, R10, R11, and R12, who have been identified as a high risk for elopement by the facility.

Findings include:

1. R3's Admission Record, undated, documents R3 was admitted to the facility on 2/22/23.

R3's Electronic Medical Record, documents R3's diagnoses include Alzheimer's Disease, Dementia, Anxiety Disorder, Major Depressive Disorder, Multiple Sclerosis, and Asthma.

R3's Minimum Data Set (MDS), dated 3/3/23, documents R3 has a severe cognitive impairment and requires Supervision to Limited Assistance from one staff member for all her Activities of Daily Living (ADLs) including ambulation.

R3's Care Plan Focus, dated 2/24/23, documented R3 is at risk for falls due to her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF GODFREY	1623 29 WEST DELMAR GODFREY, IL 62035

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S9999	Continued From page 3	S9999		

cognitive deficit, history of falls, and poor balance. R3's Care Plan, updated 3/17/23, documents, "(R3) is at high risk for elopement r/t (related to) exit seeking behavior." The Care Plan Interventions to address this focused problems documented with the initiation dates are as follows: 3/17/23 Allow concerns to be expressed, monitor whereabouts as needed or PRN (as needed) when she is compliant; 3/17/23 Praise resident when cooperative; 3/24/23 When wandering increases, redirect into common areas, encourage reminiscing with resident; 4/18/23 MD (Medical Doctor) notification PRN; 4/18/2023 enhanced supervision; and 4/19/23 Enhanced Supervision with 1:1." R3's Care Plan focused area, dated 3/17/23, documents, "(R3) Demonstrates significant mood distress/depression related to wanting to leave facility." The Interventions to address this focus problem were as follows with the following initiation dates: 3/17/23, Communicate care, empathy, sensitivity, and compassion for the resident and what he/she is going through while educating the person on the stages of grief and loss, discuss factors that interfere with the above in counseling. It continues, "(R3) is under the services of (Local Hospice) care due to a terminal diagnosis." It continues, "(R3) is at high risk for falls r/t dx (diagnosis) of Alzheimer's, being unsteady on feet and forgetting to use wheelchair at times. Interventions: Monitor for changes in gait or ability to ambulate, keep bed in lowest position, floor mats while in bed, fall risk assessment quarterly and as needed, encourage resident to keep room free of obstacles/ clutter; 4/11/23: Attempt to redirect resident when near inaccessible areas." It continues, "(R3) has a self-care deficit in ambulation r/t weakness. Interventions: 1. Explain procedure to (R3). 2. Apply gait belt. 3. Lock wheelchair brakes. 4.

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	IL6001028	A. BUILDING: _____ B. WING _____	C 05/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF GODFREY	1623 29 WEST DELMAR GODFREY, IL 62035

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S9999	Continued From page 4 Assist to standing position. 5. Supervise (R3) to ambulate from room to dining room to meals three times a day. 6. Encourage to ambulate full distance. 7. Allow for periods of rest if needed or appears tired. 8. May pull w/c (wheelchair) behind for safety. 8. Praise all efforts." R3's Elopement Evaluation, dated 2/22/23, documents R3 has a No Risk for Elopement. R3's Nurse's Note, dated 3/13/23 at 1:45 PM, documents "Administrator: Resident very confused. Making multiple attempts to exit building. Staff are remaining 1:1 with resident. Calls made to family to update them about resident exit seeking and becoming angry and aggressive. Daughter states that she is notable to return until Wednesday and she does not think that it is a good idea for her mom to call and talk to her husband. Resident attempted to pull the fire box off the wall. she pinched Admin hand. Unable to redirect resident. Resident safety is priority." R3's Nurse's Note, dated 3/13/23 at 2:48 PM, documents, "Resident had increased behaviors this shift, resident was trying to escape building, pull fire alarm, and was sticking her nails into staff skin, hospice, notified with N.O. (new order) for Zyprexa 5 MG (milligram) BID (twice a day) and 5 MG daily PRN mid-day." R3's Nurse's Note, dated 3/16/23 at 9:08 PM, documents, "Resident has been up all shift, not easily to redirect. She is currently in bed, resting, call light in reach." R3's Nurse's Note, dated 3/18/23 at 9:26 PM, documents, "Resident continues with (Local Hospice), alert with confusion. Resident requiring	S9999		

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	IL6001028	A. BUILDING: _____ B. WING _____	C 05/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF GODFREY	1623 29 WEST DELMAR GODFREY, IL 62035

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S9999	Continued From page 5	S9999		

redirection and 1 to 1 care most of evening. Medication compliant with no other issues, resting in bed with call light in reach."

R3's Nurse's Note, dated 3/24/23 at 9:58 PM, documents, "Around 6:50 PM resident escaped out back door on 200-hall with her wheelchair and a diaper on her head in the rain. Retrieved resident and brought her back in facility. No injuries noted. Notified administrator."

On 5/2/23 at 7:45 PM, V7, Certified Nurse's Aide (CNA), stated, "I was here when (R3) eloped on 3/24/23 around 6:40 PM. I was at the front door because my fiancé brought me a delivery, it was raining so we were standing at the front door waiting for it to lighten up, when I happened to look outside and saw (R3) standing at the street corner holding her wheelchair and a clean (incontinence brief) on top of her head to keep the rain off her. I grabbed the Nurse that night and we ran out and got her back in. When I got back inside, I was hearing the door alarm still going off, and no one had checked it. I think we were short staffed that night. The next morning, I told the DON who said she knew nothing about it. Nobody even asked me anything else about it. I know everyone knew about it because people were laughing at the fact that she had a (incontinence brief) on her head."

R3's Nurse's Note, dated 3/24/23 at 9:59 PM, documents, "Resident remains on (Local Hospice). She went to bed before 8:00 PM and did not take her evening medicine. Will give if she wakes up. She is exit seeking and needs constant observation."

There were no documented changes to R3's Care Plan until 3/17/23, with R3 having exit

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF GODFREY	1623 29 WEST DELMAR GODFREY, IL 62035

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S9999	Continued From page 6	S9999		

seeking behaviors documented on 3/13/23 and 3/16/23. There was no elopement risk assessment completed after R3's multiple attempts to exit, until R3 eloped from the facility on 3/24/23.

R3's Elopement Evaluation, dated 3/24/23, documents R3 as a High Risk for elopement, although there is documentation in R3's Nurse's Notes, dated 3/13/23, that she was exit seeking.

R3's Nurse's Note, dated 4/11/23 at 6:16 PM, documents, "At around 5:35 PM, resident was pushing her wheelchair into the kitchen and fell just inside the door. ROM (Range of Motion) X four WNL (within normal limit), eyes PERRLA (Pupils Equal Round Reactive Light and Accommodation). She states her right hand and fingers hurt, but she has arthritis also. She is confused and wanders constantly. Notified NP (Nurse Practitioner), who ordered X-ray of right hand and fingers. X-ray order put in. Notified her family member."

R3's Nurse's Note, dated 4/15/23 at 2:01 AM, documents, "Resident remains on (Local Hospice). Resident was up walking earlier in shift going in and out of other rooms and trying to take their stuff and trying to exit out the front door. Finally settled down and went to bed. Call light within reach."

R3's Nurse's Note, dated 4/16/23 at 10:03 PM, documents, "Resident remains on (Local Hospice). She is up and down all shift, wandering about the facility. She is exit seeking and needs to be watched."

R3's Nurse's Note, dated 4/17/23 at 00:16 AM, documents, "Resident continues on (Local

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001028	A. BUILDING: _____ B. WING _____	C 05/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF GODFREY	1623 29 WEST DELMAR GODFREY, IL 62035

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S9999	Continued From page 7 Hospice). Up walking the halls. No complaints or concerns at this time." R3's Nurse's Note, dated 4/17/23 at 11:46 AM, documents, "Resident continues hospice care. Hospice nurses in facility today to see resident. No new orders received at this time. Resident continues to be non-compliant with ambulation status and is encouraged to ambulate with assistance. Resident denies pain or discomfort at this time. pleasant and cooperative with staff and care. Will continue to monitor." R3's Nurse's Note, dated 4/18/23 at 6:58 PM, documents, "Resident wanders around facility. Redirection and reassurance is given. Hospice care continues. Frequent contact for ensured patient safety." There is no further documentation in R3's Nurse's Notes that identified R3 eloped from the facility on 4/18/23. The Facility's Incident Report, dated 4/18/23, documents, "Nursing Description: Resident exiting facility unauthorized. Resident wearing long sleeve sweater, blue jeans, and pink slippers. Outside temperature was approximately 63 degrees and dry. Resident Description: I went for a walk, no I didn't, I was with the people that help me. Immediate Action Taken: Resident assessment: skin, pain, and psychosocial completed. MD and family notified. Initiating enhanced supervision." This Incident Report did not document where R3 was found, who found R3, and at what time she was found. V6's, Registered Nurse/RN, written statement, dated 4/18/23, documented, "I heard an alarm go off. I stood up from my seat to further hear where	S9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF GODFREY	1623 29 WEST DELMAR GODFREY, IL 62035

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S9999	Continued From page 8	S9999		

the sound was coming. I noticed 2 CNAs on 200 side of the building and asked them to check the door and reset the alarm. This was around 19:15. I heard the alarm shortly after, and again request the CNAs on my hall to check and reset the alarm. I also requested them to make sure the door wasn't ajar. Around 19:45 PM, a couple arrived @ (at the front door. They were escorting (R3). The couple stated 'We found her sitting in our car. She was talking to our friend in front of our mom's condo.'"

On 5/2/23 at 7:10 PM, V6 stated, "I was here when (R3) eloped. I had two CNAs working on that hall that night. One CNA was sitting in a chair in the hall and the other was with a resident at that time. (R3) wandered around a lot so we made her a one-on-one. The staff were all aware to keep an eye on her. At around 7:15 PM on 4/18/23, I heard a door alarm going off, both CNAs were on the hall, so I figured they had it under control. I had to yell down the hall for them to check the door. One CNA reset the code. Then the door alarm went off again and I asked them if they pulled the door shut, so they did and reset the alarm again. I don't know how they didn't see (R3), or hear the alarm if they were down the hall. I was relying on the CNAs to keep an eye on her. Nobody knew that (R3) was gone until around 7:45 PM, when a couple showed up at the front door with (R3) and stated that (R3) was at their condo. (R3) had on jeans, a long sleeve sweater, and pink slippers. (R3) had the remote to her television in one hand and her roommates lunch slip in the other hand. I think that is how the couple knew she came from here. No one, including myself, went outside to do a perimeter check to look for a resident until the managers showed up. Then we all did a resident check. The CNAs are always on their phone with earbuds in,

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	IL6001028	A. BUILDING: _____ B. WING _____	C 05/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF GODFREY	1623 29 WEST DELMAR GODFREY, IL 62035

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S9999	Continued From page 9	S9999		

so that may be the reason they didn't hear the alarm. I feel like we had enough staff that night, however, the staff that were here were not doing their jobs, and no one is holding them responsible. I do know that the one-on-one for (R3) is happening 24 hours a day now, including nights. (R3) always walks around the facility, and I know that she got out about two to three weeks ago (3/24/23) while it was raining, and staff went out and brought her back in."

V23's, CNA, written statement, undated, documented, "I was working 2:30-10 PM shift, where resident, (R3) got out the building. She was not assigned to my group, but eyes were kept on her until around 7p. During that time, I was assisting my residents to bathroom and to bed when this incident occurred."

V25's, CNA, written statement, dated 4/18/23, documents, "I (V25) was on 100 hall putting resident to bed. So, I was in their rooms when the alarm was going off. I couldn't hear because their TV is always on, and you cannot hear the alarm. So I was doing my job. (R3) is a fast lady she gets around she is to [sic] much to handle when you have a group to do she need to be a 1 on 1, but I am sorry for what happened but I am glad she is ok and made if back safe."

V24's, CNA, written statement, dated 4/18/23, documents, "I was helping another CNA put a resident to bed. I heard the alarm go off constantly so after I was done helping I went to put the code in and turned it off. As I was into another resident's room, the alarm went off again, I did the same think and turned it off but this time, I pulled the door all the way up. I also went out the same door going for my break but I never seen a resident outside."

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF GODFREY	1623 29 WEST DELMAR GODFREY, IL 62035

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S9999	Continued From page 10	S9999		

V26's, RN, written stated, dated 4/18/23, documents "I (V26), was working on April 18, 2023 when resident (R3) eloped. I took my break after I finished my first med pass and documentation at approximately 1900. I finished my break and came back inside approximately 1915 through the front door. As I walked in, I got to the nurses' station and a CNA asked 'Where's the alarm coming from?' It sounded like two alarms were going off. I checked the front door and found I had not latched the door all the way so I looked outside for anyone, didn't see anyone outside and closed the door fully and reset the alarm. I walked back to my assigned hall (100) after hearing the staff members on 200 were addressing a door alarm at the end of that hallway. I began my med pass, checking that all my resident were present and accounted for they were. I continued with my med pass. At approximately 1945, I was notified that there was an elopement on the 200 hall. Resident, (R3) was brought to the nurses' station to being enhanced monitoring."

On 5/2/23, V4, Neighbor, at 11:02 AM, stated, "I live in the subdivision next to the nursing home, and I have a Ring camera that points toward the nursing home." V4 stated, "When I looked at it, I saw a little old lady walking around by herself. Then approximately thirty minutes later, I saw some residents from the subdivision walking her back to the nursing home. I couldn't see where exactly she went or how far she got, but I did see them walking her back. I called the nursing home after I saw the video, and no one answered the phone. I called the nursing home hotline, which is what the answering machine said to do." V4 stated she was concerned as "this is a busy road if she would have gotten out on the main road,

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BRIA OF GODFREY	1623 29 WEST DELMAR GODFREY, IL 62035

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S9999	Continued From page 11	S9999		

she could have been killed."

On 5/2/23 at 1:30 PM, V5, Certified Nursing Assistant (CNA), stated, "I was here when (R3) got out. We all heard alarms going off, but couldn't figure out where they were coming from. I first went to the 300-hall, but that wasn't it, so by time I got to the 200-hall, the CNA who was working that hall shut off the alarm, but then it came back on. I think the door was not closed all the way. I used the restroom, and when I got out, they told me that (R3) got out and then some people brought her back. The Maintenance man is the one who told me that he watched the facility's video from the camera in the hall, and it looked like (R3) had punched in some numbers on the keypad and pushed the door open. She may have thought she was putting in the correct code and went on out. There was not a room to room search for residents until the management team arrived. I was told that (R3) had on her slippers but not sure about a coat or anything else."

On 5/2/23 at 3:32 PM, V2, Director of Nursing (DON), stated, "I was called in that night, and I know when I got here, we did a room-to-room search of all residents. I cannot say if it was done prior to my arrival."

On 5/2/23 at 3:50 PM, V5, CNA, stated, "(R3) went out the door at the end of her hall. The managers watched it on the camera and saw her enter a code and exited the door. They said (R3) must have watched a staff member enter the codes and either memorized it, or knew that the code would open the door, and when no one was around, she attempted to put the code in and then exited. All the big shots came in and investigated it. We all got in-serviced on

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	IL6001028	A. BUILDING: _____ B. WING _____	C 05/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF GODFREY	1623 29 WEST DELMAR GODFREY, IL 62035

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S9999	Continued From page 12	S9999		

elopements, and they changed all the combinations on every door. Now (R3) is a one-on-one for elopement risk."

On 5/4/23 at 2:35 PM, V14, Maintenance Director, stated, "I was called in on 4/18/23 after that lady (R3) got out. I checked all the doors, and that door (R3) went out seemed to be faulty. That door alarm worked when opened, but I believe the magnetic lock was faulty, and once the door closed, it would quit chirping. If the door didn't close all the way, the alarm would still sound. I have since fixed this issue. I check all the doors in the facility every day. I have nothing documented that I checked the doors prior to 4/18/23, but now I have a form to complete every day to document things like that. I started in April 2023 so cannot speak if drills were done prior to 4/18/23. I have been doing elopement drills just about every day. I did one on the evening (4/18/23) that lady got out and we have been doing them since. I can tell you that there is still a lot of work to be done yet."

On 5/4/23 at 12:25 PM, V2 stated, "I would expect all staff to respond to any door alarm and to follow the facility's policy on elopement. I would expect all staff to check the perimeter of the building, inside and out, if a door alarm goes off without visibly seeing a resident exit the building."

On 5/3/23, the facility provided the following information which identified the residents who were at risk for elopement:
-R2's Elopement Evaluation, dated 4/18/23, documented R2 was at high risk for elopement.
-R4's Elopement Evaluations, dated 11/23/22 and 4/18/23, documented R4 was at high risk for elopement.
-R7's Elopement Evaluation, dated 2/24 and

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	IL6001028	A. BUILDING: _____ B. WING _____	C 05/08/2023

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S9999	Continued From page 13 4/18/23, documented R7 was at high risk for elopement. -R8's Elopement Evaluation, dated 4/18 and 5/2/23, documented R8 was at high risk for elopement. -R9's Elopement Evaluation, dated 3/22 and 4/18/23, documented R9 was at high risk for elopement. -R10's elopement Evaluation, dated 3/1/23, documented R10 was at high risk for elopement. -R11's Elopement Evaluations, dated 4/18 and 5/2/23, documented R11 was at high risk for elopement. -R12's Elopement Evaluation, dated 12/19/22, documented R12 was at high risk for elopement. The Facility's "Elopement Policy", dated 4/2023, documents "Elopement occurs when a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so. This does not include alert and oriented residents who handle themselves outside the facility and choose to leave the facility, even if against medical advice and sometimes, common on sense. While presenting different care challenges, these alert residents are not in the same category of potential danger as the residents with impaired cognition trying to leave the facility, and their absences from the facility are not considered to be an elopement. Residents who are at risk to elope are closely supervised to keep them safe in their environment, while allowing them to move freely about the safe environment. 1. Any resident identified as an elopement risk will have pictures available, one kept at the reception desk and the others in a facility-designated area. 4. Residents at risk to elope will be closely monitored. 6. Access doors on some units are alarmed so that staff can secure the environment rather than the	S9999		

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S9999	Continued From page 14	S9999		

resident and can intercede when a resident wants to leave the unit or safe area. When possible, staff is advised to walk with the resident off the unit or area, rather than restrict him from leaving. 7. All staff are responsible for responding to a door/elevator alarm immediately. This response will include visual check on the immediate vicinity surrounding the door/elevator that tripped the alarm, including the stairwells and outside area. 11. If someone identified at risk to elope is discovered missing from the unit, the Resident Elopement Plan is followed."

The Facility's "Elopement Policy", updated 5/2023, documents "Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. A resident who leaves a safe area may be at risk of (or has the potential to experience) heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle. This does not include alert and oriented residents who handle themselves outside the facility and choose to leave the facility, even if against medical advice and sometimes, common sense. While presenting different care challenges, these alert residents are not in the same category of potential danger as the residents with impaired cognition trying to leave the facility, and their absences from the facility are not considered to be an elopement. Procedure: 1. Upon admission, designated facility staff will complete the elopement observation. 2. Any resident identified at risk to elope will be reviewed every 90 days or with significant change in condition. 3. If a resident not determined to be a risk for elopement, and at a later date develops elopement behaviors, then the resident will be

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S9999	Continued From page 15	S9999		

reviewed at the time and then quarterly until they are no longer an elopement risk. General: Residents who are at high risk to elope are placed on enhanced supervision to keep them safe in their environment, while allowing them to move freely about the safe environment. Guideline: 1. Any resident identified as an elopement risk will have pictures available, one kept at the Reception Desk and the others in a facility-designated area. 2. Any resident identified at risk to elope upon admission will have the Elopement Risk identified and included in the Interim Plan of Care. A comprehensive elopement prevention plan of care will be developed at the first care plan meeting. The plan will be reviewed at least every 90 days or more often if necessary. 3. There will be a Master List of all residents at risk to elope. The Social Service Department or designated staff will update the list as additional residents are determined to be at risk to elope and it will be reviewed weekly. The list will be available at the nurses' stations and reception area. 4. Residents at risk to elope will be closely monitored. 5. The Activity and Nursing staff together provide a variety of programs and items designed to help redirect residents into safe areas. 6. Access doors on some units are alarmed so that staff can secure the environment rather than the resident and can intercede when a resident wants to leave the unit or safe area. When possible, staff is advised to walk with the resident off the unit or area, rather than restrict him from leaving. 7. All facility staff are responsible for responding to a door alarm immediately. This response will include visual check of the immediate vicinity surrounding the door that tripped the alarm, including the stairwells and outside area. 8. If a cause for the alarm sounding cannot be immediately determined, a head count on all

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S9999	Continued From page 16 residents is completed utilizing a resident roster. 9. If the cause of the alarm is the resident attempting to leave the unit, the following measures will be taken: a. Resident will be redirected to the unit b. Additional monitoring of the resident as determined by the IDT. c. Update care plan as appropriate." (B)	S9999		