Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009765	A. BUILDING: ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATSEKA REHAB & HLTH CARE CTR	715 EAST RAYMOND ROAD WATSEKA, IL 60970

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S 000	Initial Comments Complaint Survey: 2365318/IL161418 & 2365237/IL161321	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6 Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	S9999	Attachment A Statement of Licensure Violations	

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

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care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These Requirements were not met as evidenced by:

Failures at this level required more than one deficient practice statement.

A. Based on observation, interview and record review the facility failed to ensure staff were supervising residents, failed to ensure qualified staff were transferring residents, and failed to ensure bed wheels were locked to prevent accidents. The facility also failed to conduct fall investigations, develop and implement fall interventions, and complete neurological assessments after falls/accidents for three of five residents (R1, R3 and R4) reviewed for accidents in the sample list of ten residents. Failing to ensure trained/qualified staff were transferring R3 resulted in R3 falling from the wheelchair and suffering a head wound requiring seven staples.

B. Based on interview and record review the facility failed to provide supervision to prevent a resident elopement for one of five residents (R10) reviewed for accidents in the sample of ten residents.

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Findings include:

a.
1.) R3's undated medical diagnosis list documents medical diagnoses of Intellectual Disabilities, Muscle Weakness, Need for Assistance for Personal Care, Unsteadiness of Feet, Abnormalities of Gait and Mobility, Anxiety, Delusional Disorders and history of Right Femur Fracture.

R3's Minimum Data Set (MDS) dated 5/22/23 documents R3 as severely cognitively impaired. This same MDS documents R3 as requiring limited assistance of one person for bed mobility and walking in room, and extensive assistance of two people for transfers, locomotion on and off unit, toileting and personal hygiene.

R3's Physician Order Sheet (POS) dated June 1-30, 2023 documents a physician order dated 4/3/23 for Aspirin Enteric Coated (EC) 81 milligrams (mg) daily.

R3's Fall Risk Evaluation dated 6/14/23 documents R3 as a high fall risk.

R3's Medical Record documents R3 is on continual monitoring for history of falls.

R3's Nurse Progress Note dated 6/14/23 at 8:06 PM documents "(R3) was returning from bathroom in wheelchair when began to move impulsively and threw self out of wheelchair. Noted to have approximately two inch laceration over Right Eye. Area cleansed et dressing applied."

R3's Hospital Discharge Summary dated 6/14/23

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documents R3's chief complaint as 'fall, laceration' and discharge diagnosis as 'Laceration of Forehead'. This same report documents R3's scalp laceration was repaired. This same report documents "89 year old fell from (R3's) wheelchair at facility and hit his forehead sustaining laceration. (R3's) bleeding was stopped with pressure dressing." This same hospital report documents R3 received seven staples to Right Forehead just above Right Eye due to fall.

R3's Final Incident Report to Illinois Department of Public Health dated 6/20/23 documents R3 fell in R3's room while being transferred from wheelchair to bed by (V24) Unit Aid on 6/14/23. (V24's) Unit Aid written witness statement documents "I was assisting (R3) back into his room from the bathroom in his wheelchair. I put the wheelchair facing the chair I sit in and proceeded to walk from behind the wheelchair towards my chair. As I started to walk around (R3) used his feet to move the wheelchair forward, got his feet caught up and slid out of the chair and fell into his side dresser. I called for a Certified Nurse Aide (CNA) and a CNA and a Nurse assisted (R3) up onto (R3's) bed."

R3's Nurse Progress Note dated 6/24/23 at 4:00 AM documents "(R3) was found on floor of hallway. Emergency services called and (R3) transferred to emergency room."

R3's Electronic Medical Record (EMR) does not document Neurological assessments completed for 72 hours or fall investigations after R3's 6/14/23 fall nor 6/24/23 fall.

R3's Care Plan does not document new fall interventions after R3's 6/14/23 nor 6/24/23 falls.

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On 6/28/23 at 2:05 PM Observed R3 laying on covers in bed. Observed R3's Left Elbow to have a dark purple bruise approximately small orange sized, R3's Left mid Forearm to have a dark purple baseball sized bruise on outer side, and R3's top of Left Hand to have a baseball sized fading purple and gray bruise. Observed R3's Right Forehead just above Right Eyebrow to be bruised with marks where staples had been removed earlier in day.

On 6/29/23 at 11:50 AM (V9) Regional Director of Operations stated "(R3) had a fall early morning of 6/24. The staff called me and said (V16) Unit Aide was supposed to be continuously monitoring (R3), (V16) fell asleep, (R3) got up and walked out into the hallway and fell."

On 6/29/23 at 2:15 PM V1 Administrator stated R3 fell on 6/14/23 while being transferred by V24 Unit Aid. V1 stated Unit Aids are not trained to transfer, toilet or assist with feeding of residents. V1 stated "(V24) Unit Aid should never have assisted (R3) with transferring. This led to (R3's) fall with a major injury. (R3) ended up with staples in his forehead." V1 stated V24 should have asked for help transferring R3. V1 Administrator stated "Maybe this wouldn't have happened if (V24) would have asked for help. (V24) Unit Aid has already been educated on this."

2.) R4's undated Face Sheet documents medical diagnoses of Seizure Disorder, Schizoaffective Disorder and Depression.

R4's Minimum Data Set (MDS) dated 4/10/23 documents R4 is severely cognitively impaired. This same MDS documents R4 requires

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extensive assistance of one person for bed mobility, transfers, dressing, eating and personal hygiene, and extensive assistance of two people for toileting.

R4's Nurse Progress Note dated 6/7/23 at 12:25 AM documents "Facility staff actions/interventions and response at time of the event: (R4) was assessed area found to Right Forehead with a approximately one inch laceration and a half dollar sized bump. Follow up recommendations to manage the resident's condition and needs: to keep area to Forehead dry and clean, watch for any signs and/or symptoms of seizure due to head trauma"

R4's Nurse Progress Note dated 6/7/23 at 1:54 AM documents "(R4) was pushing a chair and stumbled and hit head causing a small laceration to Right side of Forehead and a half dollar size bump. (R4) wound was cleansed and bandaged. Ambulance was called to transport to emergency room for treatment. Around 8:15 PM emergency room called to inform that (R4) was set to discharge. Emergency room glued the laceration and are monitoring (R4). Update called for (R4) is sleeping at this time, wound to head has been glued, (R4) getting Intravenous fluids for hydration and (R4) had been given Haldol and Ativan due to increased anxiety."

R4's Nurse Progress Note dated 6/18/23 at 8:07 AM documents "(R4) was in dining area and staff stated (R4) fell on another resident's arm. (R4) balance is always unstable."

R4's Nurse Progress Note dated 6/20/23 at 3:46 PM documents "(R4) walked into wall per staff and observed blood to wall by bed. (R4) has open area to Right side of Forehead. First-aid

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rendered. Tylenol given for pain management. Ambulance called."

R4's Nurse Progress Note dated 6/20/23 at 4:20 PM documents "(R4) observed standing by wall in bedroom by staff . Observed blood coming from (R4's) head and noted blood stain on wall. First aid rendered. Ambulance called. Physician aware to send to emergency room for further evaluation."

R4's Nurse Progress Note dated 6/21/23 at 7:30 AM documents "At approximately 7:10 AM this morning (V12) Licensed Practical Nurse (LPN) was in hallway speaking with staff when (V12) saw staff run towards (R4's) room. (R4) was trying to get on floor (normal behavior). (R4's) head slid down the wall as (R4) was getting on the floor. Noted to have reopened wound on top of (R4's) head. Minimal bleeding noted."

R4's Nurse Progress Note dated 6/21/23 at 2:21 PM documents "(V12) LPN was informed by staff that (R4) hit the floor; witnessed; it was explained to (V12) that (R4) tripped over the wheelchair wheel of the chair (R4) was sitting in and hit (R4's) head; noted that (R4) reopened wound that had the steri strips; steri strips removed."

R4's Electronic Medical Record (EMR) does not document a fall investigation nor neurological assessments after R4's 6/7/23 fall with head injury. This same EMR does not document Neurological Assessments after R4's head injuries on 6/20/23 and twice on 6/21/23.

R4's Care Plan does not document any new fall interventions after 6/6/23. This same care plan documents an intervention to encourage R4 to not crawl on the floor.

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On 6/27/23 at 11:15 AM Observed R4 to bend down to a crawling position on hands and knees on the floor in the Dementia Unit hallway

On 6/27/23 at 11:16 AM Observed V7 Certified Nurse Aide (CNA) observe R4 crawl on the floor of the Dementia Unit. V7 CNA did not encourage R4 to not crawl on the floor.

On 6/28/23 at 12:00 PM Observed R4 bend down to a crawling position on hands and knees on the floor. V18 Dementia Unit Coordinator was standing by watching R4. V18 did not encourage R4 to not crawl on floor.

On 6/29/23 at 9:00 AM Observed R4 bed down to a crawling position on hands and knees on the hallway floor with other residents within reach of R4. V19 and V20 Certified Nurse Aides (CNA) walked by R4 two times each without offering R4 assistance to stand up or not crawl on floor.

On 6/27/23 at 11:20 AM V7 Certified Nurse Aide (CNA) stated "(R4) likes to crawl around on the floor. (R4) used to be a carpenter so he thinks he is nailing boards to the floor. (R4) is careplanned for crawling on the floor."

On 6/28/23 at 12:05 PM V18 Dementia Unit Coordinator stated R4 is careplanned to crawl on the floor. V18 stated "(R4) crawls on the floor all the time. (R4) is always bumping his head all the time down there."

On 6/29/23 at 9:03 AM V19 Certified Nurse Aide (CNA) stated as she was walking by R4 crawling on the floor "(R4) does that all the time. (R4) bumps his head a lot. I don't know why they (facility) doesn't do something about that."

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On 6/29/23 at 9:05 AM V20 Certified Nurse Aide (CNA) stated "I am agency. I don't know these residents at all. I don't know how to see their careplan. I just do what the other staff do."

On 6/29/23 at 2:45 PM V1 Administrator stated "(R4) crawls on the floor all the time. Every time I go back to the Dementia Unit, it seems like (R4) is crawling around on the floor. I thought (R4) was careplanned for that. I do know (R4) bumps his head a lot and also falls. The staff should add fall interventions with each new fall and implement the fall interventions to prevent a resident from falling the same way again. It is obvious that this isn't happening. I don't know if (R4's) major injury (head wound) could have been prevented but we can certainly reduce the risk of him falling or having these accidents that cause him head injuries."

On 6/29/23 at 1:00 PM V3 Interim Director of Nurses (DON) stated "I have been working with our staff to try to use the careplan. The staff can't use the careplan if there isn't one or if the resident careplan is not updated. (R4) should not be crawling on the floor. We (staff) know that (R4) has had multiple head injuries from crawling on the floor. This needs to stop. (R4) is really going to get hurt one of these times. (R4) already had sutures from a fall. We (facility) had two Certified Nurse Aides (CNA) that day (R4) fell and busted his head open. Both CNA's were agency and did not know the residents well. This facility does have a lot of agency staff. I think that is part of the problem. With every head injury or unwitnessed fall the staff should complete three days of Neurological Assessments. Staff did not do that in any of these times (R4) had falls or accidents. We (facility) also did not do a fall

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investigation. We (facility) really do have a lot of work to do."

3.) R1's Electronic Medical Record (EMR) documents R1 as severely cognitively impaired.

R1's Fall Risk Assessment documents R1 as a fall risk.

R1's Care Plan does not document a focus area, goal nor interventions for R1 being at risk of falls.

R1's EMR documents R1 as requiring supervision with transfers, toileting and locomotion.

R1's Nurse Progress Note dated 6/25/23 at 5:40 AM documents R1 was found sitting on floor next to R1's bed in R1's room early morning of 6/25/23.

R1's EMR does not document a fall investigation initiated until 6/29/23.

R1's Hospital Record dated 6/25/23 documents R1's discharge diagnosis as "Contusion of Head".

R1's Final Incident Report to Illinois Department of Public Health (IDPH) dated 6/29/23 documents R1 had a large Hematoma to Right Forehead noted at time of fall. This same report documents root cause "(R1) attempted to get out of bed and bed was not locked and moved away from (R1) as she attempted to get up."

On 6/27/23 at 11:10 AM Observed R1 with dark purple and black circular bruising all the way around both eyes. This same bruising also extended above (R1's) Right Eye to mid forehead. Observed R1 walking independently in the hall of the dementia unit.

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On 6/27/23 at 11:12 AM R1 stated "You should see the other guy!" As R1 making a fist with Right hand and punching palm of R1's Left hand. R1 stated R1 did not know how R1's face got bruised. R1 stated (expletive) like this doesn't happen every day. I don't know how it happened but it sure does hurt!."

On 6/27/23 at 9:20 AM V18 Dementia Unit Coordinator stated "They (staff) told me (R1) fell over the weekend and got those bruises on her face. I don't know how (R1) fell. No one told me that. I don't see any thing about falls on (R1's) careplan. The staff would not know what interventions were put into place if it is not listed on the careplan. We (facility) have a lot of agency staff so those staff especially need to be able to see the resident careplan. I haven't done any training's on this unit for fall preventions or reporting of injuries. They (facility) never told me to do that."

On 6/29/23 at 10:20 AM V3 Interim Director of Nurses (DON) stated the facility did not do a fall investigation for R1's fall until 6/29/23. V3 stated "We (facility) have been so busy with so many other things. I got it done today but truthfully I didn't start it until today either."

The facility policy titled Fall Prevention revised 11/10/18 documents Appropriate interventions will be implemented for residents determined to be at high risk at the time of admission for up to 72 hours. The unit nurse will place documentation of the circumstances of a fall in the nurses notes or on an Assess/Intercommunicate/Manage (AIM) for Wellness form along with any new intervention deemed to be appropriate at the time. Report all falls during the morning Quality Assurance

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meetings Monday through Friday. All falls will be discussed in the Morning Quality Assurance meeting and any new interventions will be written on the care plan. All staff must observe residents for safety. If residents with a high risk code are observed up or getting up. Help must be summoned or assistance must be provide to the resident.

The facility policy titled Emergency Care Head Injury reviewed 12/22/17 documents residents should be evaluated for head injuries for a minimum period of 72 hours to determine any negative effects, and to allow for immediate treatment to minimize permanent damage. The following procedure focuses on proper assessment of residents who have sustained a head trauma. Secure the resident from further danger, assess the resident including vital signs, consciousness and neurological (neuro) status, immobilize resident's head and neck, assign staff to remain with resident, notify physician immediately. Ongoing assessment (vital signs and neurological checks) should take place as follows: Initially and every 15 minutes for one hour, every 30 minutes for one hour, every hour for four hours, every four hours for eight hours, every shift for the remainder of 72 hours. Assessments for the first 24 hours after injury shall be recorded on the Neurological/Head Trauma Assessment Form (Neuro Assessment Sheet). Additional documentation shall be recorded in the clinical record. Complete a Quality Care Tracking form and document all observations and occurrences.

b.
1) R10's Undated Face Sheet documents medical diagnoses of Psychotic Disorder with

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Hallucinations due to known Physiological Conditions, Cerebral Vascular Accident (CVA), Flaccid Hemiplegia Affecting Unspecified Side, Hypertension, Diabetes Mellitus, Muscle Weakness, Difficulty in Walking and Major Depressive Disorder.

R10's Minimum Data Set (MDS) dated 5/22/23 documents R10 as moderately cognitively impaired. This same MDS documents R10 as requiring supervision for bed mobility, transfers, locomotion off unit, and eating, and assistance of one person for locomotion on unit, dressing, toileting and personal hygiene.

R10's Careplan does not include an elopement focus area, goal nor interventions.

R10's Electronic Medical Record (EMR) does not include an elopement risk after R10's elopement on 5/27/23.

R10's Nurse Progress Note dated 5/27/23 at 10:12 AM documents "Received a phone call that (R10) was leaving the facility and was going towards baseball park by self and that he got combative with staff and had verbal aggression. (R10) has been spoke to about leaving facility supervised with family. This writer called non-emergency police to help with (R10). Non-emergency police arrived and spoke to (R10) and staff helped (R10) go back into facility."

R10's Nurse Progress Note dated 6/10/23 at 12:51 PM documents "Received a call from facility that (R10) left without supervision, called the family and they had said (R10) will be coming to their house which is a few blocks away from facility and (R10) is having a home visit."

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	IL6009765	A. BUILDING: ____ B. WING ____	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATSEKA REHAB & HLTH CARE CTR	715 EAST RAYMOND ROAD WATSEKA, IL 60970

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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R10's Nurse Progress Note dated 6/10/23 at 11:01 PM documents "(R10) returned from family visit at (9:45 PM). (V27) (R10's) family member told staff that he fell in their driveway. (R10) stated he had "A lot of beer and some fireball." (R10) has multiple wounds: two on Right Upper Forearm both skin tears. First 1.0 centimeters (cm) x.01cm, second 1.0 cm x .01cm cleansed and approximated steri-strips applied, (R10) has an open area to Right knee 2cm x 1.5cm cleansed and dry dressing applied, has open blister to both great toes on the Right .5cm x .2cm at the knuckle, on the Left great toe just below the nail .3cm x .2cm sure prep applied to both."

R10's Nurse Progress Note dated 6/22/23 at 6:22 PM documents "(R10) went outside this morning and was seen in both the front and back of the building. One on one was provide to ensure (R10) did not leave building."

On 6/27/23 at 3:00 PM observed R10 using R10's Left hand and arm to propel self slowly in the wheelchair in the hallway. Observed R10's Right Foot on foot pedal and R10's Urinary Catheter tubing dragging floor underneath R10's wheelchair.

On 6/29/23 at 10:45 AM V25 (R10's) Power of Attorney (POA) for Healthcare stated "No one let me know (R10) was leaving without permission. (R10) needs to be supervised. (R10's) thinking was changed after he had his stroke. (R10) definitely should not be wheeling himself around town. That is so dangerous. (R10) could get hit by a car or something. I am just picturing (R10) wheeling himself down the road. How awful. I don't have any problem if (R10) wants to go visit his family in town but that place needs to keep a

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better eye on him and make sure he gets there and back safely."

On 6/29/23 at 1:45 PM R10 stated "I left two times (5/27,6/10). They (facility) didn't even know where I was. (V27) (R10's) family member had to call them (facility) and say I was at (V27's) house. It is easy to get out of here. I just roll out the front door. I just wait until the staff are busy and roll right on out. (V27) knew I was coming over. (V27) lives just down the road a couple of miles. I made it to (V27's) house ok both times before so I thought I could do it again. But, that last time they (facility) caught me." R10 stated "If I can't get a ride to (V27's) house then I will just take myself there again."

On 6/29/23 at 11:25 AM V26 Social Service Director (SSD) stated R10 has a diagnosis of a Psychotic Disorder and has been seeing behavioral health services through the facility. V26 stated R10 has had multiple angry outbursts due to his previous Cerebral Vascular Accident (CVA). V26 stated "On 5/27/23 (R10) wheeled himself out of the facility and left the property. (V28) (R10's) family member called the facility to report that (V28) saw (R10) wheeling himself down by the ball park a few blocks away. I called the non-emergency police. We (staff) and the police all went out looking for (R10). (R10) ended up at (V27) (R10's) family member's house. This is a couple of miles away from the facility. (R10) was intoxicated when he returned to facility later that night. Then again on 6/10/23 (R10) pretty much did the same thing. (R10) wheeled himself out of facility. (R10) wheeled himself across town again to (V27's) (R10's) family member's house. (V27) called the facility to let us (staff) know that (V27) would bring (R10) back after a family barbecue. (R10) was later returned to facility by

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(V27's) friend. When (R10) returned to facility he was intoxicated again." V26 SSD stated "From what I understand the police found (R10) between a major retailer and the cemetery which is a little over two miles away. The police escorted (R10) the rest of the way to (V27's) house. When we (facility) went looking for (R10) we never did find him. The police found him. (R10) is not able to make sound decisions and should have been supervised more closely."

On 6/29/23 at V29 Physician stated "(R10) may belong in a different type of facility where they can manage his behaviors. (R10) should be more closely supervised due to (R10) eloping from facility twice before and attempted a third time. (R10) could get ran over by a car if he is wheeling himself down the center of the highway. It sounds to me like (R10) has an alcohol addiction and uses very poor judgement." V29 stated the facility is responsible for R10's safety. V29 stated the facility should supervise R10 more closely.

On 6/29/23 at 3:20 PM V1 Administrator stated "After (R10) eloped from this facility on 5/27/23, we (facility) made a new rule that every resident regardless of their cognitive status had to be supervised when outside of the facility and on the property by staff or family. We (facility) did not put anything specifically in place for (R10). (R10) sits up in the dining room a lot which is by the front door. The exit doors are alarmed but (R10) is strong enough to push himself through the front doors. This should not have happened once, much less twice. The second time (R10) eloped on 6/10/23 our staff just simply weren't paying attention. (R10) could have gotten hurt so badly. A car could have not seen (R10) and ran into him. I don't even want to think about what all the bad consequences would be if (R10) was struck by a

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S9999	Continued From page 16 car as he was wheeling himself down the middle of the highway." The facility policy titled Elopement Prevention Policy revised 10/06 documents the staff will assess all residents for the potential for elopement. Determination of risk will be assigned for each individual resident and intervention for prevention will be established in the plan of care to minimize the risk for elopement. A licensed nurse will complete the Elopement Risk Assessment upon and/or within eight hours of admission to the facility. An interim plan of care for minimizing the risk for elopement will be initiated upon high risk determination. A facility staff member will take a photograph of the resident upon or within eight hours of admission. The photograph will be placed in the Medication Administration Record (MAR). Any resident assessed to be at high risk for elopement will have their photograph and basic identifying information placed in a special folder or binder to be maintained at the nurses station. The Interdisciplinary Team (IDT) will initiate a plan of care for any resident determined high risk for elopement. Facility specific measures as well as resident specific measures will be included in each high risk resident's plan of care to minimize risk factors. Interventions of person door alarm devices and monitoring will be initiated as deemed necessary by the IDT and documented in the individual resident's plan of care. Any high risk resident will be promptly and courteously escorted back to the appropriate nursing unit, activity room, dining area or resident room when noted to be near an exit door. Revision of the Elopement Risk Assessment will be completed quarterly, after an isolated elopement attempt, monthly for resident who attempt elopement more than five times per week, upon a resident	S9999		

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S9999	Continued From page 17 significant change in condition and as needed, determined by the IDT. The plan of care for minimizing elopement risks will be reviewed each time the Risk Assessment is completed with initials and dating of the care plan by any member of the IDT present for review. All employees will be educated within a reasonable timeframe of hire and throughout the year with elopement education on the location of the elopement file/binder and Elopement Prevention Policy. (A)	S9999		