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S 000	Initial Comments Annual Health Survey	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 care needs of the resident.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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: Based on observation, interview, and record review the facility failed to prevent elopement by failing to identify behaviors of wandering/exit seeking and elopement, re-evaluate for risk of elopement, notify the physician and family of exit seeking behaviors, and develop/implement targeted behavior tracking and person-centered interventions to address exit seeking behavior for one resident (R11) reviewed for elopement in the sample list of 14. This failure resulted in R11, a resident with a known history of exit seeking and diagnosis of Dementia, leaving the facility alone and unnoticed by climbing through a window. R11 was found by a member of the community, approximately two tenths of a mile on a residential street/roadway without sidewalks, a state highway and railroad tracks approximately a quarter mile away, wearing dark clothing, while using a walker, by himself(R11) on the side of the road. R11 had the potential for serious injury and/or death of being struck by a motor vehicle or falling. Findings include:	S9999		

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S9999	Continued From page 2 The facility's incident summary of R11's elopement documents on 5/11/23 at approximately 8:10 PM another resident (R12) notified staff that R12 observed R11 exit the facility. The Elopement Policy was activated, a search was initiated, and R11 was found at approximately 8:20 PM and returned to the facility. The incident investigation dated 5/11/23 and 5/12/23 document V10 Labor & Delivery Nurse brought R11 back to the facility, and R11 had been found on Lawrence Street (approximately two tenths of a mile away from the facility). R11 told V10 that R11 was going to R11's hometown. R12 was interviewed and recalls seeing R11 climb out of the window. R12 did not notify staff because R12 did not want R11 upset with R12. A local web based weather application documents sunset was at 8:00 PM on 5/11/23. R11's Minimum Data Set (MDS) dated 3/3/23 documents R11 has a Brief Interview for Mental Status (BIMS) score of 7 indicating severe cognitive impairment, and R11 did not have any wandering behaviors noted during the 7 day review period. R11's MDS dated 5/23/23 documents R11 has a BIMs score of 3, indicating severe cognitive impairment, and wandering occurred 4-6 days during the 7 day review period. R11's Nursing Notes document the following: On 3/7/23 at 2:06 PM R11 attempted to walk out the front door of the facility twice. On 3/12/23 at 5:09 AM R11 set off the door alarm and was found by the door. R11 stated R11 wanted to go out to R11's car to get something. On 3/15/23 at 2:46 AM R11's departure alert system activated the door alarm near the facility's entrance and R11	S9999		

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was redirected to the living room area. R11 stated R11 wanted to leave. On 3/16/23 at 3:18 AM R11 wandered down the east hall and attempted to open the door to the garden. On 3/18/23 at 4:34 AM R11 went outside to look for R11's car and was brought back into the facility. R11's departure alert system had not activated the door alarm. A second departure alert device was added to R11's wheeled walker. On 4/7/23 at 6:56 PM staff observed R11 exiting the building and intercepted R11 in the parking lot. On 4/14/23 at 11:30 PM R11 insisted on leaving the facility to go to R11's hometown.

R11's Care Plan dated 5/23/23 does not document any new interventions were developed/implemented to address R11's wandering and exit seeking behaviors after 3/20/23 until 5/11/23. The intervention dated 3/20/23 documents R11 has a departure alert device on R11 and on R11's walker, staff are to redirect R11 to R11's room after supper, and turn on western television shows. There is no documentation that R11's wandering/exit seeking behaviors were routinely tracked and monitored including the development and implementation of nonpharmacological interventions to respond to R11's behaviors.

There are no documented elopement risk assessments completed in R11's medical record after 3/8/23 until 5/23/23. There is no documentation that R11's physician and family were notified of R11's exit seeking and wandering behaviors until 5/11/23 after R11 eloped from the facility.

On 5/30/23 at 1:23 PM the perimeter of the facility near the sunroom was observed. There is a concrete slab adjacent to the windows, landscape

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S9999	Continued From page 4 rock and bushes, and a grassy 45 degree berm that leads to an uneven, grass yard. The concrete slab does not connect to a sidewalk. There is a sidewalk to the east of the sunroom, across the grass yard, that does not connect to the street. On 5/30/23 at 4:15 PM 19th Street (East/West street where facility is located) does not contain sidewalks. There is no shoulder or curb and approximately 1 foot of gravel on each side of the road with grassy ditches. 19th Street intersects with Lawrence Street approximately 1/4 mile away from the facility. There is no stop sign when heading North on Lawrence Street at this intersection. Lawrence Street does not contain a sidewalk, shoulder, or curb. There is approximately 1 foot of gravel on each side of the road with grassy ditches. Railroad tracks and Highway 54 are South of where R11 was found, approximately 1/4 mile away. On 5/30/23 at 1:03 PM R11 stated R11 recalls getting out of the facility a few weeks ago. R11 stated R11 climbed out the facility window when no one was looking, and R11 was trying to get to R11's hometown. R11 stated R11 walked down the road that evening and someone picked R11 up and brought R11 back to the facility. R11 stated there were no sidewalks, so R11 had to walk on the edge of the road. On 5/30/23 at 11:20 AM V9 (R12's Family) stated V9 received a call from R12 around 8:15 PM on 5/11/23 reporting that R11 got out of the facility through the sunroom window, and no staff had witnessed R11 leave the facility. R12 told V9 that R11 knew not to go through the doors due to R11's departure alert device, and R11 was wanting to go to R11's hometown. V9 stated R12 reported the incident to the nurses prior to calling V9.	S9999		

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S9999	Continued From page 5 On 5/30/23 at 11:30 AM V8 (R11's Power of Attorney) stated the facility notified V8 that R11 escaped out of the sunroom window and was found down the road from the hospital. V8 stated R11 has a history of going near the exit doors, but had never tried to leave the facility prior to this incident. On 5/30/23 at 11:47 AM V10 Labor & Delivery Nurse stated V10 was on V10's way home from work on 5/11/23 at approximately 8:20 PM-8:30 PM. V10 was driving on Lawrence Street and saw R11 in dark clothing, walking South, with R11's walker on the side of the road in the gravel. V10 stated V10 thought it was abnormal, was concerned that R11 was going to get hit by a vehicle, and V10 offered R11 a ride. R11 told V10 that R11 lived "around the bend." V10 stated R11 got into R11's van, and V10 drove R11 around asking if any of the houses were R11's. V10 then asked R11 for R11's address and R11 gave R11's hometown as R11's address. R11 was unaware of what town R11 was currently in. V10 asked about R11's family, discovered R11 was a resident of the facility, and brought R11 back to the facility. On 5/30/23 at 11:58 AM V11 Registered Nurse stated V11 was conducting door alarm checks in March, R11 was out in the parking lot and was trying to get back into the facility through the main entrance. V11 stated no staff had witnessed R11 leave the facility and R11's departure alert device did not alarm. The device was functional, but V11 believed it did not activate due to R11 wearing multiple shirts. V11 stated the 4/7/23 incident was witnessed by staff, and R11 was looking for R11's car. V11 could not recall if V11 notified R11's family of R11's exit seeking behaviors or	S9999		

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elopement on 3/18/23, and V11 stated V11 did not notify V7 (R11's Physician). V11 stated R11 is alert and oriented to person, not place and time, and does not have good safety awareness and decision making ability. R11's exit seeking behaviors seem to be close to the first hour of change of shift from days to evenings, and V11 believes R11's behaviors are triggered by watching staff leave.

On 5/30/23 at 5:39 PM V15 Certified Nursing Assistant (CNA) stated on 5/11/23 V15 last saw R11 at approximately 7:00 PM in the living room area with R12. V15 was first made aware that R11 was out of the facility when R12 stopped V15 in the hallway at about 8:10 PM. V15 stated R12 told V15 that R12 was upset because R12 and R11 got into an argument and R12 saw R11 leave the facility through the sunroom window. R11 had exited the facility sometime between 7 and 8:00 PM. V15 stated V15 immediately went to the sunroom and the middle window was open with the screen removed. V15 immediately went outside to see if V15 could see R11, V15 did not see R11 and reported the incident to V14 Registered Nurse (RN). V15 stated an elopement check was initiated and V14 and V15 continued to search for R11 outside of the facility. V15 stated it was just starting to get dark around 8:10 PM, and V10 located and returned R11 at approximately 8:30 PM.

On 5/31/23 at 7:19 AM V14 RN stated during the evening medication pass V15 told me that R12 witnessed R11 leave the facility through the sunroom window. We went outside near the window, and were unable to locate R11. V14 stated V14 instructed the other nurse and CNA to conduct a head count of all other residents while V14 and V15 continued to search for R11 outside.

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S9999	Continued From page 7 V14 had last seen R11 between 6:30 PM and 7:00 PM. On 5/30/23 at 2:28 PM V3 MDS Coordinator confirmed R11's care plan does not identify new interventions to address R11's exit seeking behaviors after 3/20/23 until 5/11/23. On 5/30/23 at 11:01 AM V2 Director of Nursing stated R11 left the facility through the sunroom window on 5/11/23, and R12 witnessed the incident but did not report to staff right away. V2 stated R12 called and reported the incident to V9 (R12's Family) who is also an employee of the facility. R11 was found down the road near the stop sign, East of the hospital. On 5/30/23 at 12:43 PM V2 stated elopement risk assessments are documented in the resident's paper chart and completed quarterly and as needed. V2 stated if the resident has a change in cognition or a change then an elopement risk assessment is done. V2 stated R11 has always been at risk for elopement since R11 admitted and wears a departure alert device. On 5/30/23 at 2:06 PM V2 stated V2 reviewed the surveillance camera footage and R11 went down the grassy berm, and walked to the sidewalk by the building. V2 stated physician and family notification would be documented in a progress note and confirmed R11 had no targeted behavior tracking for R11's wandering/exit seeking behaviors. On 5/31/23 at 9:57 AM V2 stated the video surveillance inside the facility showed R11 heading to the dining room at 7:45 PM, and there were two CNAs at the desk. V2 stated at 7:46 PM R11 headed towards the sunroom and R12 was in the living room area, and at 7:56 PM R11 showed up on the camera outside of the facility near the sunroom. V2 confirmed there is no documentation of interventions implemented	S9999		

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S9999	Continued From page 8 between 3/20/23 and prior to 5/11/23 or that the physician and family were notified to address R11's exit seeking and wandering behaviors. The facility's Wandering Resident/Elopement policy revised 10/3/18 documents: Wandering behaviors will be documented in the medical record. Observations of wandering behaviors will determine the level of supervision needed. Residents will be assessed for elopement risk quarterly and with significant changes in condition, and the care plan updated as needed. Residents at risk for elopement will have interventions that include the use of a departure alert device, and their care plan updated to include behaviors with specific goals and interventions. Residents who have eloped from the facility will have interventions including visual checks every 30 minutes for 24 hours initiated when the resident attempts to leave the facility more than once in a 24 hour period. Notify the family and physician of the behavior. (A)	S9999		