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S 000	Initial Comments Complaint Investigations 2425650/IL175720, 2425657/IL175706	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.690a) 300.690b) 300.690c) 300.1210b) 300.1210c) 300.1210d)3)6) 300.1220b)3) 300.3100d)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. 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	S9999		

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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.

b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.

c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

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

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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.

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.

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

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are ordered by the physician, shall be involved in the preparation of the resident care 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.

Section 300.3100 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 requirements were not met as evidenced by:

Based on observation, interview and record review, the facility failed to prevent a resident with known wandering and exit seeking behaviors from leaving the facility without staff supervision for one of four residents (R1) reviewed for elopement in a sample of four. R1 was last seen by staff in the facility on 7/13/24 at 6:00 pm and was located three days later (7/16/24) on a local park bench, approximately two and a half miles from the facility, in 90-degree Fahrenheit temperature. This failure resulted in R1 requiring transportation to the local hospital for evaluation and treatment. This failure has the potential to affect all Elopement Risk Residents residing in the facility.

Findings include:

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Accu-weather documents: low temperature on 7/13/24 was 72 degrees Fahrenheit/F and a high of 91 degrees F; low temperature on 7/14/24 was 73 degrees F and a high of 90 degrees F; low temperature on 7/15/24 was 68 degrees F and a high of 93 degrees F; and low temperature on 7/16/24 was 70 degrees F and a high of 82 degrees F.

Google Maps documents the facility is approximately two and a half miles from the address where R1 was located on a park bench.

Facility Elopement Prevention Policy, revised 10/2006, documents: It is the Facility Policy to provide a safe and secure environment for all Residents; to ensure this process, the staff will assess all Residents for potential elopement; determination of risk will be assigned for each individual resident and interventions for prevention be established in the plan of care to minimize the risk of elopement; at the time of screening and/or upon admission, ask the Resident/Representative/Family/Past Care Givers if the Resident has a history of wandering or 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; staff will take a photograph of the Resident and photograph will be placed in the Medication Administration Record and the Resident will have their photograph and basic identifying information placed in a special folder/binder to be maintained at the Nurse's Station; Department Supervisors will be provided with a listing of Residents at high risk for elopement and will disclose this information to their employees as necessary; the Interdisciplinary Team/IDT will initiate a plan of

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care for any Resident determined high risk for elopement and specific measures will be included in each high risk Resident's plan of care to minimize risk factors and communication of these interventions will be made to direct care staff through exposure to the Resident's plan of care and periodic review and disclosure of the contents' of Elopement File/Binder; 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 and after an isolated elopement attempt, monthly for Residents who attempt elopement more than five times a week and upon significant change in condition and as needed; 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; and any employee will be educated within a reasonable time frame of hire and throughout the year with elopement education on the location of the elopement file/binder and Elopement Prevention Policy.

Facility Missing Resident Policy, revised 8/13/24, documents: It is the Facility policy reasonable precautions are taken to minimize the risks of Resident elopement attempts; reasonable precautions include, but are not limited to door alarms, staff intervention, staff education regarding door alarms and individual resident intervention; is the policy of the Facility to demand immediate response to elopement attempts, door alarm activation and participation in search attempts in the even a Resident is deemed missing; a Resident is deemed missing when an initial reasonable search of the Facility interior

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and immediate grounds has not rendered physical evidence of the Resident's person, there exists no evidence of the Resident's whereabouts upon examination of documents including but not limited to the medical record, calendar of events and sign out books/sheets and after questioning of Facility staff and residents evidence of whereabouts remains uncertain; when a Resident fails to return from community outing within a reasonable time frame of estimated time of return or within reasonable time frame of known and established past habits/patterns; it is the staff responsibility to immediately notify the Charge Nurse; report to the Charge Nurse for assignment; conduct a search of the Facility interior including under beds, closets, bathrooms, storage areas, laundry/maintenance areas and to conduct a sweep of areas with staff members working together to sweep each consecutive room to avoid the possibility of Resident moving to adjacent rooms undetected and to interview people of unimpaired cognitive ability for possible sightings; conduct a search of the Facility grounds including outdoor buildings/sheds/garages, parked cars, ditches and interview people on the grounds; expand the search to the neighborhood streets and yards within four to five blocks of the Facility if unable to locate on Facility premises; continue to expand the search until the Resident is located and returned to the Facility; the Charge Nurse/Director of Nursing/DON responsibility is to determine when and where the Resident was last seen, notify the Administrator, DON, Department Supervisors, auxiliary staff, off duty staff to assist in the search; notify the Responsible Party/Guardian/Family and notify the attending Physician; Administrator responsibility is to notify the Regional Director of Operations and/or Director of Clinical Operations upon designation

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of Resident "missing," notify Law Enforcement officials and request assistance if the Resident is not located on the premises or surrounding immediate neighborhood and facilitate/coordinate staff assistance in investigation/search under the direction of Law Enforcement; after return to the Facility conduct a complete assessment, initiate Emergency Care Policy, notify personnel involved in the search the Resident has been located (Responsible Party, Administrator, DON, Department Supervisors, Attending Physician and Law Enforcement); complete a Quality Care Reporting Form, document all observations, assessments, interventions and Resident response in the medical record; conduct a thorough Investigation Report of Missing Resident and report the findings to the Quality Assurance/QA Committee with a timeline of occurrences, interventions and responses and prepare a report of staff performance; report as required by State and Federal regulation to the appropriate regulatory agencies; and review of the occurrence in the morning QA meeting to establish a Facility specific strategy to prevent further occurrence.

Facility Assessment Tool, dated 8/18/2017, documents: The purpose of the assessment is to determine what resources are necessary to care for Residents competently during day-to-day operations and emergencies, to provide care allows Residents to maintain/attain their highest practicable physical, mental and psychosocial well-being; Appendix PP provides survey guidance through interpretive Guidelines in the State Operations Manual if systemic care concerns are identified are related to the Facility's planning, review of Assessment to determine if these concerns are considered part of the Assessment process; other medical diagnoses or

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conditions may be considered for admission and the QA team will meet and identify any new needs or resources needed to provide care and support for the person; the Resident's care is based on their individual needs (i.e., enteral tube feeding, preferences and routines, provide culturally competent care, identify hazards and risks for Resident; and develop, implement and maintain an effective training program for staff; ensure providing competent care to Residents every day and during emergencies.

Facility Resident Rights, dated 11/2018, documents: The Facility must provide equal access to quality care regardless of diagnosis, condition or payment source; must provide services to keep your physical and mental health at highest practicable levels; be safe; develop a person-centered Care Plan including personal and cultural choices and must make reasonable arrangements to meet your needs and choices; you have the right to move out of your Facility after you give the Administrator, Nurse or Doctor written notice you plan to move and your discharge plan and steps to achieve the goal should be included in your Care Plan; and before your Facility can transfer or discharge you it must prepare you to be sure your discharge is safe and appropriate.

On 7/18/24, the Facility Elopement Risk Binder did not document a Resident Information Sheet/Picture for R1 but contained a handwritten note R1 is an identified Elopement Risk. R2, R3, and R4 are documented as Elopement Risk Residents and have a Resident Information Sheet/Picture.

R1's Hospital Discharge History and Physical, dated 5/13/24, documents R1 requires: 24-hour

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care and physical assistance and supervision due to decreased cognition, command following, decreased Upper Extremity Range of Motion, dependence on Activities of Daily Living; and requires Speech Therapy and Occupational Therapy.

R1's Physician Order Sheet/POS, dated 5/17/24 through 7/13/24, documents R1 admitted to the facility on 5/17/24 and V14 (R1's Physician) has "read and approves the Plan of Care." R1's POS documents diagnoses including Acute Respiratory Failure with Hypoxia and Hypercapnia, Closed Fracture of the Occipital Bone and Occipital Condyle, Intraparenchymal Hemorrhage of the Brain, Traumatic Subdural Hematoma, Subarachnoid Hemorrhage status post internal Hemorrhoid Ligation, Alcohol and Cocaine Abuse, Hyponatremia, Back Injury, history of Lumbar Disc Herniation, Anemia, Acute Encephalopathy, history of Falls and Altered Mental Status R1's Physician Order Sheets do not document a Discharge Order for R1.

R1's New Admission Information Sheet, undated, documents R1 admitted to the facility on 5/17/24 and R1's Emergency contact person is V11 (R1's Sister) and V12 (R1's Brother-n-Law).

R1's Interdisciplinary Discharge Summary for Resident, dated 5/17/24, documents R1 requires staff assistance with Activities of Daily Living/ADLs, needs medication assistance, is not oriented to time and place, meal preparation service is necessary and requires a wheelchair.

R1's Facility Admission Screening Form notes (handwritten on untitled blank paper), dated 5/17/24, documents: R1 admitted to the Facility a mechanical lift for transfers; had a Cervical Collar

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(C-Collar) to stay on at all times for one month, and the Facility to schedule a follow-up Computed Tomography laboratory test (CT Scan) in one month for removal of the C-Collar; "talks but is confused"; has a Gastrostomy Tube (G-tube) being used for medications; and speaks Spanish.

R1's Medication Administration Record/MAR, dated 7/1/24 through 7/14/24, documents R1 was "out" (of facility) for R1's 7/13/24 8:00 pm medications. All medications on 7/14/24 document R1 was "out of facility."

R1's Nursing Notes, dated 5/17/24 through 7/13/24, do not document on 7/13/24. R1 exited the building and was not able to be located.

On 7/18/24 and 7/19/24, the facility could not provide or locate documentation of R1's Nursing Notes from the dates of 5/29/24 through 7/14/24 at 6:00 am. On 7/19/24 at 10:28 am, after multiple requests, V1 (Administrator) stated, "We do not have any Nursing Note documentation for (R1) for the time period of 5/29/24 through 7/14/24 at 6:00 am. I cannot provide any Nurse's Notes about the events of (R1) getting out of the building."

On 7/18/24 at 12:08 pm, V2 (Director of Nursing/DON) stated, "We do not have any Nursing documentation for (R1) for the time period of 5/29/24 through 7/14/24 at 6:00 am. On 7/19/24 V2 stated, "I still cannot find any of (R1's) Nursing documentation for the time period of 5/29/24 through 7/14/24 at 6:00 am, we just do not have any. I also do not see anyone charted the events surrounding when (R1) went missing or anyone notified (V14/R1's Doctor) (R1) was missing."

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R1's Minimum Data Set/MDS, dated 7/13/24, documents R1 requires setup with Activities of Daily Living.

R1's A.I.M. for Wellness Assessments (used to notify the Physician), dated 5/17/24 through 7/13/24, do not document a 7/13/24 entry for R1 exiting/eloping the building.

R1's Elopement Evaluation, dated 5/17/24, documents an entry R1 had physical impairments requiring assistance outside of the building and R1 had severe Mental Illness/CVA (Cerebrovascular Accident)/Brain Injury/Traumatic Brain Injury/Alzheimer's or Dementia. No evaluation updates were documented on R1's Elopement Evaluation.

R1's Social Service Progress Notes, dated 5/17/24, documents R1 admitted to the Facility and "uses a wheelchair to move around." The Progress Note also documents R1 will be a "rehabilitation to home so the Social Service Director will contact the appropriate agencies before discharge."

R1's Prescreen of Risk for Violence, dated 5/17/24, documents R1 has been the victim of physical or sexual abuse, has poor impulse control, risk taking or reckless behavior, currently use of alcohol/recreational drugs, had a recent relapse of substance abuse and was physically able to harm others.

R1's Prescreening/Screening Assessment for Harmful Behaviors, dated 5/17/24, documents: R1's history of talking about/threatening harm/aggressive behaviors towards others; talking about/threatening self-harm, suicide or engage in self-destructive behaviors; maintains

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considerable anger and hostility/strong dislikes towards others; and has a history of addictive substances and recognizes chemical addition as self-destructive behavior."

R1's current Care Plan, undated, documents: incontinence complications with bowel/bladder; risk for falls related to history of Hypoxia and Respiratory Failure and do not leave unattended in the bathroom; arrange for discharge as needed, discuss feelings/goals for placement, share concerns, involve family/friends, obtain Physician order for discharge, set up services for durable medical equipment as needed for safe discharge and Social Services to intervene as needed.

R1's Fall Risk Assessment, dated 5/17/24, documents R1 is a high Fall Risk.

R1's Bowel and Bladder Assessment, dated 5/17/24, documents R1 "will begin therapy."

R1's Quality Assurance/QAT Progress Notes, dated 5/12/24 through 7/13/24, do not document R1's exit from the building or exit seeking behaviors.

R1's Release of Responsibility for Discharge Against Medical Advice, dated 7/16/24, is incomplete and does not document implications of discharge against medical advice, following alternatives or R1 assuming responsibility of care. On 7/18/24 at 1:10 pm, V1 (AIT) verified the Release was filled out three days after R1 exited the building and is incomplete.

The Police Department Event Report (24-110644) dated 7/14/24, documents the Police arrived at the Facility on 7/14/24 at 12:47 am for a Missing

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Person complaint and documents "(R1) followed a visitor out of the front doors" and (V1/AIT) "still did not want to report (R1) as missing at this time."

R1's Hospital History and Physical/H&P, date of service 7/16/24, documents R1 "presents with leg swelling" and "per chart review, patient eloped from Skilled Nursing Facility (SNF) a few days ago and was found on a park bench today with swollen legs" and was "transferred to (a nearby local Hospital) after seeing abnormal findings on a head Computed Tomography (CT)." The H&P also documents: R1 was asleep, and R1 stated R1 was sleepy because R1 had been walking a lot for the past few days and R1 could not recall how R1 got to the Hospital and does not remember if R1 was in the park earlier today; R1 was unsure if R1 had a fall over the past few days, but R1 did recall R1 fell into dumpster's a few months ago, which led him to the Hospital a couple months ago; R1 endorses bilateral leg swelling, tenderness and erythema; R1 stated R1 had blisters on the soles of bilateral feet, with suspected onset a few days ago; R1 used a C-collar (cervical collar) but took it off three days ago; R1 currently states neck pain with chronic headache on the back of the head; imaging test results document an Acute Left Frontal Convexity Subdural Hematoma and Encephalomalacia in the Anterior Frontal Lobes new since prior CT; positive for dizziness, light-headedness, numbness in bilateral fingers and headaches; and PEG (percutaneous endoscopic gastrostomy) tube in place. The H&P documents R1 assessment and active Hospital Problem as Acute on Chronic intracranial subdural hematoma and leg swelling (Stasis Dermatitis versus/vs. Cellulitis vs. new onset Congestive Heart Failure vs. Deep Vein Thrombosis vs. Lymphedema vs.

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Peripheral Vascular Disease).

The Facility Admission/Discharge Report, dated 6/1/24 through 7/18/24, documents on 7/13/24, R1 was discharged to "other." The Report does not document R1's discharge to home, another Facility or a Hospital.

On 7/18/24 at 12:17 pm, V3 (Maintenance Director) stated, "I heard (R1) got out of the building and we all showed up to look for (R1), but we could not find (R1). Then I heard (V5) went and picked (R1) up from a park bench and took him to the Hospital."

On 7/18/24 at 11:40 am, V5 (Housekeeping Supervisor) stated, "I got called to the Facility very late on Saturday, 7/13/24, because (R1) went missing. Everyone was looking for (R1), we had people look all over the Facility, outside on the property and I even volunteered to go into the woods behind the Facility and I searched for him and called his name out for well over an hour and could never find him. Then we started looking in the nearby neighborhoods and still could not find him. We were all here until the early hours, on 7/14/24, looking for him. We even had off duty Certified Nursing Assistant/CNAs) looking for him and staff over the next couple of days. Then, my wife called me, she was going to a doctor's appointment, on 7/16/24 around 9:30 am, and she saw him sleeping on a park bench near the Medical Center here in town. So, I immediately called (V1/AIT) and went over and picked (R1) up and took (R1) to the hospital. (R1) told me (R1) had been walking so much, (R1's) feet to knees hurt so bad. I asked (R1) if (R1) was hungry and (R1) did say (R1) had just eaten a cheeseburger. (R1) was gone from the night of 7/13/24 through 7/16/24 and (R1) looked pretty rough and (R1's)

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legs were so swollen. I saw (R1) setting off the door alarms multiple times. (R1) was always setting off the door alarms. Just a few weeks ago, (R1) got out of the B Hall door and I caught up with him, and just walked with him around the entire building, to let him get some exercise."

On 7/22/24 at 7:58 am, V10 (R1's Brother-n-Law) stated, "(R1) left and they took him to the hospital."

On 7/23/24 at 2:49 pm, V16 (Care Plan Nurse/Licensed Practical Nurse/LPN) stated, "I was never informed (R1) was exit seeking. The staff should be telling me, so I can get it on R1's Care Plan."

On 7/23/24 at 5:49 am, V12 (Police Officer) and V13 (Police Officer) jointly stated, "On 7/14/24 around 12:30 or 12:45 am, (V12 and V13) both responded to a call from the Facility, for a missing person. When we asked (V1/AIT) about (R1's) status and medical condition, they told us (V12 and V13) (R1) was not an endangered person and did not want us to report (R1) as missing. (V1) said when (V1) checked the camera's it looked like (R1) walked right out of the front door, earlier night around 7:30 pm, and a lot of staff had already tried to locate (R1) but were unsuccessful. We were not aware (R1) had a feeding tube and needed medical assistance, because they did not tell us any of. We searched the surrounding areas for (R1) and were unable to locate (R1). Then a couple days later we received a phone call a staff member's family (Spouse) found (R1) on a park bench and they took (R1) to the hospital, so we no longer needed to search for (R1)."

On 7/18/24 at 3:53 pm, V6 (Registered

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Nurse/RN) stated, "July 13, 2024, was my first day back and I had not been at facility for a long time. My shift started at 6:00 pm, I got report and started my medication pass. Around 8:30 pm, (V7/Certified Nursing Assistant/CNA) came and told me when (V7) checked on (R1), (V7) could not find (R1). I never even saw (R1) the entire time, and do not even really know (R1). Some of the staff did say (R1) was known to walk around and get lost in the Facility a lot and was even known to attempt to go outside, and they would have to redirect (R1). I was busy passing my medication and getting report, so I had not seen (R1) either at this point. We notified V2 (Director of Nursing/DON), then made sure to check every room and the building looking for (R1). The last time anyone saw (R1) was determined to be at dinner, which would have been around 6:00 pm. They did end up looking at video surveillance and found (R1) left the building around 7:30 pm. All management staff and the Police were called, and search began for (R1). I am a 6:00 pm to 6:00 am night shift nurse, and (R1) had still not been located by the time I had left on 7/14/24 at 6:00 am. There is an Elopement binder at the Nurse's Station name people elope, but I never had time to look at it."

On 7/19/24 at 1:22 pm, V7 (Certified Nursing Assistant/CNA) stated, "I was scheduled on the 6:00 pm to 6:00 am shift the night of 7/13/24. I noticed (R1) was gone and this was not unusual for (R1) because (R1) tries to get out quite often, but I would always find him. I have a good relationship with (R1), and we bonded, and (R1) would tell me (R1) would not try and get out if I was taking care of (R1) over there (B Hall). That night, I was by myself, and it was hard to keep eyes on everyone. On 7/13/24, around 8:30 pm, I noticed (R1) was missing. I had just thought to

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myself I had not seem him yet. I had to answer three call lights first, then I went to look for (R1) and could not find him. I went and reported him missing. There were previous times I would find (R1) over on the other wing sleeping in another bed, so I then started checking every single bedroom, every closet, bathroom and every room I could possibly think of, but I could not find him. We called (V2/DON) to notify (V2), then the next thing, every manager came in. The Police were called to help to search for him, but we never found him. About three weeks ago, I personally wrote (R1's) name in the Elopement Binder at the B Hall Nursing Station, because of (R1) attempting to exit the building and getting lost in the building so much. Also, about 2 weeks ago, I noticed (R1) was going downhill a little bit more than usual and getting more confused. (R1) would take (R1's self) to the bathroom, but I would have to help clean (R1) up afterwards. (R1) also had a feeding tube they were caring for. I personally did not ever see (R1) get out of the building alone, if we saw (R1) getting out we did not let (R1) go out alone, a staff would always follow him. (R1) would attempt to get out of the building a lot and would always set the door alarms off. The whole time I ever took care of (R1), (R1) never said anything to me about leaving Against Medical Advice or eloping from the facility."

On 7/18/24 at 2:50 pm, V4 (Corporate/Clinical and Regulatory Compliance) stated, "I advised (V1/AIT) this was not an incident needed reported or investigated, because I instructed (V1) to treat it as an unplanned discharge Against Medical Advice/AMA. The Police were called, and all managers came in to search for (R1), but (R1) was never found until three days later on 7/16/24. The Facility does not normally call the local Police

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Department or Management staff in for a resident chooses to go AMA."

On 7/18/24 at 12:08 pm, V2 (Director of Nursing/DON) stated, "I got a phone call on 7/13/24 around 9:00 pm or 10:00 pm, (R1) could not be found. They had last seen (R1) around 6:00 pm. Since I got the phone call first, I came in immediately and we looked at the security camera and found out how (R1) got out. Around 7:30 pm, it showed a family member walking in the front door and (R1) walking out right at the same time. (R1) looked like a 'regular' person, so they probably did not even question (R1) leaving. We called the Police and filed a report and called in the nursing team and department heads and did a local search for (R1) and did not find (R1). We could not get a hold of (V11/R1's Sister) because none of the telephone numbers work. (R1) was semi-homeless, an immigrant and spoke mostly Spanish, but was able to understand English. The search for (R1) was stopped around 3:00 am/4:00 am on 7/14/24. On 7/16/24, when (R1) was located a few miles away, on a park bench at a Medical Complex, (V5/Housekeeping Supervisor) went and picked (R1) up and transported (R1) to the Hospital. At time, we asked (R1) to sign Against Medical Advice/AMA form. I never completed an investigation, and I cannot locate any nursing notes or anything in (R1's) medical record about (R1) leaving the building."

On 7/18/24 at 1:10 pm, V1 (Administrator in Training/AIT) stated, "Here is my timeline of events from 7/13/24, I have it on a post-it note. On 7/13/24 at 11:45 pm, (V2/Director of Nursing/DON) contact me about (R1) not being in the building. On 7/14/24 at 12:13 am, my team and I were enroute to the Facility. On 7/14/24 at

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12:49 am, I notified the local Police Department (R1) was missing. My entire staff searched the grounds/surrounding areas on 7/14/24 from at least midnight 7/14/24 at 3:00 am. I reviewed the cameras and noticed (R1) left out the front door at 7:38 pm, when a family member was coming in, (R1) went out. When we attempted to contact the family; we could not leave a message or voicemail. We considered Against Medical Advice (AMA) when (R1) left the Facility on 7/13/24. I did not do an investigation or notify Public Health of (R1) eloping, because as I said, we considered (R1) leaving AMA. (R1) did have a feeding tube, and we did not do any discharge planning or anything for (R1). I did notify the Police and we did do a search of the facility and through town for (R1) though, we do not normally call the Police or do a search for people would leave AMA. We have not offered any services such as Therapy, or screening of (R1's) Assessments and known behaviors. We cannot find any Behavior Tracking Sheets for (R1). (R1) used to come and go out of the facility on his own but would always stay close. We usually require all residents sign in and out at the front desk when leaving the facility but (R1's) is blank."

On 7/18/24 at 1:10 pm, V1 (Administrator in Training/AIT stated, "On 7/16/24, we sent (V5/Housekeeping Supervisor) to pick up (R1) from the bench and transport (R1) to the Hospital and asked (R1) sign a Release of Responsibility for Discharge Against Medical Advice." V1 (AIT) verified the Release is incomplete and was dated three days after (R1's) exit from the building.

On 7/18/24 at 1:10 pm, V1 (AIT) stated, "On 7/13/24, I got a phone call to come to the facility because (R1) was missing. I immediately tried to call (V4/Corporate/Clinical and Regulatory

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Compliance). I tried calling her about twenty times and could not get a hold of her. I then came into the facility and was here until around 3:00 am-3:30 am, searching for (R1). I called the Police when I got here and they came and searched for (R1) also, but no one could locate (R1). I do not normally call the local Police Department or ask Management staff to search for a Resident just goes AMA. A few days later, (R1) was located on a nearby park bench and transported to the hospital. (V4) finally called me back on 7/14/24 around 11:50 am, and (V4) advised me to handle it as an unplanned discharge (Against Medical Advice), so I did not think I needed to investigate it or report it to Public Health. We do not have any investigation or any documentation to provide on (R1's) exit from the building or Unplanned Discharge." V1 verified no documentation in R1's medical record was available regarding (R1) exiting the building.

On 7/19/24 at 10:10 am, V1 (AIT) stated, "(R1) used to come and go out of the facility on his own but would always stay close. We usually require all Residents sign in and out at the front desk when leaving the facility but (R1's) Sign Out/Acceptance of Responsibility for Leave of Absence sheet is blank."

On 7/25/24 at 11:00 AM, (V1/AIT) stated, "Come to find out, (R1) was exit seeking and had also attempted to get out of the facility earlier same day (7/13/24). I just found out through my investigation."

(A)