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S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 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	S9999		

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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:

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.

This requirement was not met as evidence by:

Based on interview and record review the facility failed to accurately assess a resident at risk for elopement and failed to implement interventions for a resident at risk for elopement resulting in R1 eloping form the facility unsupervised on 4/19/24 at approximately 7:00 PM. R1 did not return to the facility until approximately 1:00 PM on 4/20/24. This applies to one of three residents (R1) reviewed for elopement in the sample of eight.

The findings include:

R1's face sheet showed he was admitted to the facility on 1/22/24 with diagnoses to include activated protein c resistance, epilepsy, disorganized schizophrenia, hypothyroidism, gastro-esophageal reflux disease, Bell's Palsy, nicotine dependence, and bipolar disorder.

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R1's facility assessment dated 2/2/24 showed he was cognitively intact, required only set up assistance for cares, and was exhibiting no behaviors.

R1's care plan initiated 1/31/24 showed, "I do not show potential for discharge to the community due to current health status. Goal: Care needs will continue to be met at the facility. Interventions: Allow me to verbalize my feelings about long term care. Reassess care needs and potential for discharge as needed. Support patient, family and/or representative as needed. "

R1's care plan initiated 3/1/24 showed, "There is no plans of discharge at this time. I require assistance with ADLs (activities of daily living), mobility, and safety issues. I require, 24 hour care, will be long term... Revisit discharge plan and potential annually and PRN (as needed)... Encourage resident to be realistic in expectations, point out positives. .."

R1's complete care plan was reviewed and showed no evidence of R1 making repeated statements regarding leaving the facility or having a risk of leaving the facility unattended.

R1's 3/19/24 Psychiatry Physician Note showed, "... Recent suicidal statement... He was recently sent out to ER (emergency room) on 3/16/24 after making suicidal statements; he was reported crying "I hate this place, there is nothing to do, I'm gonna run away, I'm gonna kill myself!"... He endorses feeling down due to being stuck at his current placement..."

The facility's final investigation report to (State Agency) written by V1 Administrator and dated 4/20/24 showed, "... Resident left facility

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unauthorized... The male resident had just been outside with other residents and the monitoring staff member at the 7 PM smoke break.. Within 15-20 minutes later, he was seen by a dietary staff member who was walking home and observed [R1] walking quickly (almost running) down a street a few blocks away... The employee tried to keep eyes on him while he called the facility but the resident got out of sight and he could not locate him.... Resident has already been connected with resources to help him transition into a community setting (i.e. low income housing, halfway house, etc.) and sometimes he states he would rather live homeless than be confined in the nursing home setting. States he 'does not belong here' and wants the freedom to use marijuana to calm his anxiety. Facility will continue to seek alternate more appropriate placement for this gentleman upon his return. Conclusion: The resident was located with the assistance of his sister whom was contacted by one of [R1's] friends. The friend stated that he had shown up at his house late last night, hungry and tired, so he fed him and let him stay there... AMA (against medical advice) paperwork and consequences were discussed with him... [R1] proceeded to sign AMA paperwork stating he understand the associated risks..."

R1's AMA paperwork showed he signed out at 4/20/24 at 1:40 PM.

On 5/1/24 at 11:10 AM, V17 (Housekeeper) said she was the staff member that had taken R1 for cigarette break that evening at approximately 6:45 PM - 7:00 PM and she had taken him back up to his floor. V17 said she does not know how R1 managed to get back down and leave. V17 said they have had problems with R1 following

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the rules and he been across the street once. V17 said R1 had a lady that would come take him out sometimes and this lady took R1 downtown and left him there. V17 said R1 was found laying on a pillar downtown. V17 said one of the bus drivers recognized R1 and knew where he came from so they brought him back home. V17 said, "He was acting like he was on some other drugs. His eyes were all blood shot and he was slurring his words. He couldn't hardly walk. He stumbles at times, but this was 10 times worse... this was a week or two before this time that he disappeared... The bus driver was telling me he was acting like he was on drugs. He was getting handsy with me and I told him he needed to sit down. I called up to [his floor] to get the nurse but she did not answer. I had another resident watch him who had been sitting down there. I ran up to [R1's] floor and got the nurse. There were a few residents down in the lobby at the time [R4, R5, and R6]. CNAs (Certified Nursing Assistants) came down and got him. The nurse wouldn't even come check him out. The nurse that day was [V15 LPN (Licensed Practical Nurse)]"

R4's facility assessment dated 2/15/24 showed he has no cognitive impairment. R5's facility assessment dated 3/6/24 showed he has no cognitive impairment. R6's facility assessment dated 3/4/24 showed he has no cognitive impairment.

On 5/1/24 at 1:09 PM, V15 LPN (Licensed Practical Nurse) said she had heard from a kitchen staff member that R1 was seen down the street from the nursing home on 4/19/24. V15 said she remembered one time before that R1 left but that he had signed out that time. V15 said she didn't smell liquor or drugs on him when he was brought back and she would say he was a little

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more tired than usual. V15 said someone told her the city bus had brought him back. I wasn't right there in that area that's why I may not know what [V17 Housekeeper] had said. V15 said she heard the bus driver had seen [R1] sleeping downtown...V15 said R1 would call his sister and beg her to come pick him up and she would do it because he would get very angry with her if she didn't.

On 5/1/24 at 12:59 PM, R4 said he was in the lobby on the day R1 came in from the shuttle bus. R4 said the staff had been looking for R1 so he had come down to the lobby to see if R1 was there. R4 said R1 came stumbling in and V17 was trying to get the aides to come and get him. R4 said 2 CNAs did come down and took him back to his floor. R4 said R1 was not acting right, he was swaying, mumbling, and he had blood shot eyes that he could barely keep open. R4 said R1 mentioned to him a couple of times that he wanted to leave the facility.

On 5/1/24 at 12:32 PM, R5 said he thinks the previous incident with R1 occurred about 3 weeks ago. R5 said he and R6 were heading out to smoke when R6 got his attention and pointed out R1 in the lobby. R5 said R1 was stumbling all over the place and looked like he was groping or fighting with V17 (the housekeeper in the lobby). R5 said they went down to see what was going on. R5 said, "I started questioning him and he said he did not know how he got there. He didn't really smell like alcohol to me but he was clearly, clearly intoxicated on something... when [R1] first came in I was down at the desk and he came in from outside smelling so much like marijuana. Really strong. They would search his pockets when he would get back. Recently before he left, he said they found marijuana on him..."

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On 5/1/24 at 12:15 PM, R6 said, "[R1] had come in the door with [V17]. He looked like he was on something. Super weird dancing and walked up to [V17] and starting sexually assaulting her, grabbing her breasts. He looked like he was trying to attack her.... his eyes were beat red blood shot, [V17] tried to call up to his floor but no one answered so she ran upstairs..."

On 5/1/24 at 1:50 PM, V23 (Admission Director) said when the previous incident had occurred R1 actually had signed out and left with his friend. V23 said, "I don't know what transpired with him being with [R1's friend] but my understanding was that he was with them, he fell asleep and they didn't want to bother with him sleeping so they left him. They saw him laying on a bench and [the city bus driver] for him on a bus and brought him back. I didn't see him that day. I don't know what time they brought him back..."

On 4/30/24 at 3:10 PM, V1 Administrator said if a resident were to return from a visit with family or friends and appear intoxicated or under the influence of illicit drugs they would document the incident, educate the resident and power of attorney regarding the incident, notify the physician, and the resident's medications would be held. V1 said the facility does not drug test. V1 said the incident and the follow through would be documented in the residents progress notes in the electronic record.

On 5/3/24 at 2:23 PM, V1 Administrator confirmed the previous incident with R1 being left downtown occurred on 4/10/23. R1's complete electronic record was reviewed and showed no evidence of the 4/10/24 incident, no notification to the physician regarding the incident, no

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medications were held, and no education was documented.

The facility sign out sheets for April were reviewed and showed the last time R1's female friend signed him out of the facility was on 4/10/24.

On 5/1/24 at 3:48 PM, V24 (Dietary Cook) said he was at home at approximately 7:15 PM when he saw R1 running down the street. V24 said, "He (R1) was moving pretty fast and looked like he was trying not to be seen... It was pretty cold out there because that was before the weather started warming up. I called the facility and told them I saw him. He was alone. It seemed like it was pretty far for him to be away from the facility." V24 provided his address which is located one half mile from the facility.

On 4/30/24 at 12:14 PM, V5 CNA said in regards to the 4/19/24 incident, "... He feels like he doesn't belong here. He just wants to do his own thing. Wandered all day long.... He had been calling his parents more lately and would ask them to come get him. One time they had just brought him back and he was calling them again... I was coming back from break when I heard he was seen by a staff member down by the [local grocery store]... I was here when he came back. He seemed like he was king of high. He didn't look like himself. His eyes looked weird... It was about 1:50 PM and [V1] came up to (R1's floor) to see if someone could help pack his things because he was leaving..."

On 4/30/24 at 12:42 PM, V7 (CNA and Scheduler) said she heard from V5 that R1 was missing. We jumped in our cars and started looking. V7 said R1 was not in the elopement

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book and he doesn't have a wanderguard. V7 said R1 was always good about signing out. V7 said R1 said multiple times that he did not want to be at the facility and that he wanted to be independent. V7 said R1 made these statements throughout his stay at the facility. V7 said R1 came back to the facility on Saturday and she was up all night worried about R1. V7 said R1 stated all the time that he wanted to smoke marijuana.

On 4/30/24 at 12:28 PM, V6 ADON (Assistant Director of Nursing) said, "... I got a text around 7:30 PM that [R1] had left the building. I got in the car and spent the next 3 hours looking around the town where homeless are and where I know drug deals go down. [R1] just sleeps wherever he is, he has narcolepsy I think... He was at risk for elopement. He would take his wanderguard off consistently I've been told."

On 5/1/24 at 1:25 PM, V18 CNA said she was working on 4/19/24 when R1 left the building. V18 said, "... After dinner [R1] goes all over so you can't really watch him... One day he was looking at me and I said "what's wrong?" He said he had some marijuana, that he went and did it with his friends..." V18 said the day R1 left she had heard from another floor that someone had seen him walking. V18 said everyone started walking around looking for him and she and some others went outside and walked around..."

On 4/30/24 at 10"36 AM, V3 Activity Director said, "... [R1] always wanted to go somewhere, always wanted someone to pick him up. He would use the activity phone, his cell phone, and he used the front desk phone to call and see if someone could come get him and bring him back..."

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On 5/1/24 at 10:50 AM, V9 CNA said, "... We never had issues with him just wandering off and leaving like that. He did say a lot that he didn't belong here. Towards the middle of April I was working a lot of late shifts... He would comment a lot that he wanted to leave but he never did it..." V9 said the elevator is locked for most residents but R1 was able to use the elevator at will.

On 5/1/24 at 3:00 PM, V4 (Social Service Director) said, "... [R1] was always trying to get into arguments because he wanted to smoke marijuana. Him and his dad would get into yelling arguments because his dad didn't want certain people coming in to see him. He would always ask (about marijuana) and we would go over why we can't have it here.... There was a time that a friend came and passed him some marijuana and we got it from him... He just wanted to be able to go and do what he wanted to do which he has a right to do... I'm not even sure why he was here, I think we were providing medication management. .. He was lower functioning. We were working on discharge to a different setting... I try to keep documentation of referrals. It would normally be in their progress notes when I am working on referrals..." V4 said he did not hear about the 4/10/24 incident with R1 but that would not be the only time, depending on where he went with his friends, that he would come back looking like he was high. There was no evidence found in R1's record of V4 sending referrals or working towards discharge. V4 said the facility does not drug test residents that she knows of. V4 confirmed R1 had no emergency room visits for being under the influence.

On 5/1/24 at 10:33 AM, V16 CNA said, "[R1] definitely was a wanderer. He liked to be outside, liked to go outside and smoke and stuff. He just

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kept wanting to go outside. We try and keep the elevators locked for the residents that like to wander. He constantly was trying to leave. He would constantly ask to go outside to smoke. We have designated smoking times for residents to go out . We would try and tell him it wasn't time for his cigarette. He had to have supervision with smoking... I considered him an elopement risk. I don't know if we actually ad him on an elopement list like some of the residents who are high risk of escaping. I don't think he was on the list but he was definitely at risk. He would go and sit by the birds downstairs and try and go out in the back for an extra smoke break... He didn't like staying in one place. He was someone that we tried to keep out of the elevator. The elevators are locked for a reason. We have a key that we keep on a hook next to the elevator. During the day there are more people to watch the residents, at night there are less staff, less management so it can be harder for us so we try and keep it locked. Sometimes they get out without us knowing. Especially if they are wanting to get out. [R1] was a little sneaky about it especially at night. Last smoke break is between 7 PM and 7:30 PM, around 8 or 9 PM he would be ready for another cigarette and he would try and go down the back elevators so we didn't know. He was definitely sneaky... There were a couple of times that we would realize we hadn't seen him in a while and have to look for him. He would either be out front or out back in the smoke area. He liked to go out front a lot too..."

On 4/30/24 at 9:36 AM, V1 Administrator said, "[R1] had mental health issues and enjoyed marijuana. He was not happy. We were trying to find placement... He would routinely sign himself out and he had questionable friends. He had a friend that would pick him up and bring him back

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impaired. That night (4/19/24) he didn't sign out, he just left. We put a search party together and notified the police.. we canvased bridges, bars, etc... and couldn't find him... His sister had received contact from a mutual friend the next day and they said he had arrived at his house hungry and either cold or tired... He and his friend decided they would come in (4/20/24). He left the facility then AMA after he returned... He did not understand why we were upset. We asked ourselves over and over why he was here? He was well managed healthwise, had questionable disability mentally... He was asked to leave his sisters apartment building before because he would go knocking door to door asking for cigarettes throughout the night... When he would sign out at the front test he wouldn't usually be out overnight... he would come back late at night sometimes."

The facility's policy undated policy showed, "... Behavior Committee... Purpose: The purpose of [the facility's] behavior committee is to assist in developing a comprehensive plan of care for those residents that exhibit behaviors that are disruptive or unsafe to themselves or others... 1. The committee is comprised of individuals from Social Services, Care Plans, nursing, and others as deemed appropriate... 3. The committee will review the plan of care and behavior monitoring and tracking documentation for residents identified as having untoward behaviors in order to identify possible causes for the behavior and to identify interventions to aid in handling the behaviors... 6. Referrals will be brought to the committee through use of morning report, facility staff referral, resident/family member referrals..."

The facility's undated policy showed, "[The facility's] Drug Free Environment... Purpose: [The

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facility] believes strongly in making the living environment of all residents free of drugs and the accompanying abuses. Further the residents shall understand that the facility does not allow the use of any illegal drugs or cannibas/marijuana... If a resident chooses to participate in the use of illegal drugs inside or outside of the facility, the facility has the right to have a drug panel screening completed on the resident for confirmation. IF the resident partakes in the use of cannibas/marijuana off of facility grounds then he/she shall be evaluated by the nurse and physician shall be notified if any prescribed medications need to be held or any further steps taken to assure the residents well-being..."

The facility's undated policy showed, "Resident Elopement; Purpose: To provide a safe environment for all it's residents and to maintain their independence while safeguarding their physical well-being, both within the facility and outside of it... Procedure: 1. There will be a list of residents at risk for elopement posted at the front desk. A photo of each resident will be included. 2. All new residents will be added to this list. Once it is determined the resident is not an elopement risk the picture will be removed... 4. If a resident is found to be at risk for elopement, the resident's care plan will include interventions for the prevention of elopement. 5. If the resident is thought to have eloped, the charge nurse or designee will notify staff to do a room to room search including bathrooms, shower rooms, storage areas, kitchen, all resident rooms, and stair wells. A code "Silver" is initiated simultaneously..."
(B)