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	IL6003834	A. BUILDING: _____ B. WING _____	C 10/05/2023

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S 000	Initial Comments Facility Reported Incident of September 12, 2023/IL164447	S 000		
S9999	Final Observations Statement of Licensure Findings: 300.610a) 300.1210b) 300.1210c) 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 300.1210 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 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to monitor a cognitively impaired resident (R1), who was assessed to be at high risk for elopement and who had an electronic monitoring safety device on the right ankle; the facility staff failed to respond to alarms which may have sounded as R1 exited the building, and the facility failed to follow their elopement risk policy and procedures to prevent elopement. These failures affected R2, who speaks predominately Mandarin Chinese with limited understanding of English, who eloped from the facility on 9/12/23 without staff knowledge or supervision, has not returned to the facility and has not been located by the local police department which places R1 at a potential risk for harm when reviewed for improper nursing care in the sample of 16 elopement risk residents (R1, R3, R4, R6, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19 and R20).	S9999		

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S9999	Continued From page 2 Findings include: R1's Resident Face Sheet documents, in part, R1's diagnoses of schizoaffective, disorder bipolar type; pain; and hypokalemia. R1's admission to the facility from the hospital was documented as 8/18/23. R1's Minimum Data Set (MDS), dated 8/25/23, documents, in part, R1's Brief Interview of Mental Status (BIMS) score 6 indicating R1 has severe cognitive impairment. R1's Wandering Behavior coded as a "2" for "Behavior of this type occurred 4 to 6 days, but less than daily." R1's Wandering Impact coded as "Yes" for the question: "Does the wandering place the resident at significant risk of getting to a potentially dangerous place (e.g. (for example), stairs, outside of the facility)?" In R1's "Social Services - Elopement Risk Assessment Tool," completed on 8/21/23, V5 (Assistant Social Services Director) documents, in part, the following statements apply: 1) R1 attempted to or has an actual elopement in the last year. 2) R1 roams or wanders throughout the facility and does not respond favorably to staff redirection. 3) R1 attempts to leave the facility unsupervised and does not respond favorably to staff redirection. 4) R1 verbalizes a strong desire to leave the facility and has the ability to do so. With the above statements applying to R1, R1 was placed on the elopement risk prevention program with a corresponding plan of care with the following interventions: 1) Personal safety alarm devices. 2) Staff aware of resident on wander/elopement risk. 3) Exit and stairwell alarms. 4) Photo on potential elopement list. 5) Utilization of a check in/out log. 6) Psychological counseling/group. 7) Recreational activities. V5 documented in the comments field: "(R1) has	S9999		

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S9999	Continued From page 3	S9999		

been assessed and will be added to the elopement prevention program. (R1) IS considered an elopement risk. IDT (intradisciplinary team) and floor staff have been made aware."

On 9/19/23 at 2:28 pm, V6 (Registered Nurse, RN) stated V6 was R1's assigned nurse on 9/12/23 from 7:00 am to 3:00 pm. Surveyor asked how does V6 know who the elopement risk residents are. V6 stated, there is a list for elopement risk and electronic monitoring safety device residents, and V6 checks this posted list daily. V6 stated, "I (V6) check and make sure that the (electronic monitoring safety device) is in place and working. If I see it's not working, I will call maintenance." Surveyor asked how V6 knows if the electronic monitoring safety device is working. V6 stated, "If I see it blinking. Red blinking." V6 stated, V6 checks the electronic monitoring safety device on the residents wearing them when V6 is leaving and when V6 does rounds at the end of V6's shift to make sure it's in place. V6 showed this surveyor the Elopement Risk list posted at the 3rd floor nurse's station with 16 residents' (including R1's) photo, names gender, age, and height. Regarding 9/12/23 incident, V6 stated at 7:00 am, V6 did rounds, verified that R1's electronic monitoring safety device was functioning on the right ankle and noted R1 was on the 3rd floor. Surveyor asked about R1's orientation and activity. V6 stated, R1 was alert and oriented x 2 (person and place), walked around the floor. and R1 took R1's protein nutritional drink scheduled at 9:00 am. When asked if V6 saw R1 eating lunch, V6 stated, "I (V6) did not see (R1). The CNA saw (R1). (R1) ate." Surveyor asked how often is V6 doing rounds to check on R1. V6 stated, "Mostly CNAs do rounds. I (V6) do rounds. I saw (R1) at 2:00

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pm, in (R1's) room" and R1 was sleeping in bed. V6 stated, "I didn't want to bother (R1)." V6 stated, it's the last time that V6 saw R1 on the day shift on 9/12/23. V6 stated, "The CNA does a rounds sheet. Nurses do visual checks. CNAs go room by room and check it on paper." V6 stated, R1 is not to go out on pass unsupervised. V6 stated, "Elopement risk residents can't have a pass." Surveyor asked if a resident is going out on pass to the community, what is V6's role. V6 stated, V6 will have to sign a paper that is co-signed by the social services staff, and this independent pass only applies to residents who are oriented, taking their meds and are compliant with their behaviors. V6 stated, residents with the electronic monitoring safety devices can leave the floor to go to other floors in the facility but are not able to leave the facility by themselves. V6 stated, with R1's elopement on 9/12/23, it was not the first time that R1 had tried to leave the facility with it being the 2nd or 3rd time.

On 9/19/23 at 2:40 pm, V7 (Certified Nursing Assistant, CNA) stated, V7 worked on the 3rd floor as a CNA (not assigned to R1) on 9/12/23 from 7:00 am to 3:00 pm. V7 stated, V7 started V7's shift by checking the board to see the Elopement Risk list residents and then did morning rounds. V7 stated, "I (V7) saw (R1) eat breakfast and lunch, and I did rounds at 1:00 pm, and (R1) was asleep. I saw (R1) at 2:00 pm to give a snack in (R1's) room, and (R1) was just waking up." V7 stated that on 9/12/23, R1 was sometimes walking around the 3rd floor and would sometimes go downstairs off the floor. V7 stated that V7 did walking rounds, "final rounds," at 2:30 pm and R1 was walking on the 3rd floor. V7 stated, R1 does not speak English well and speaks primarily Chinese. V7 stated, V7 only understands a little bit of English, and R1's

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S9999	Continued From page 5 English language is not clear. V7 stated, R1's electronic monitoring safety device was located on R1's ankle and it was blinking which indicates the sensor is working. V7 stated, residents with electronic monitoring safety devices can go downstairs to the 1st floor and then back up to the 3rd floor. When asked if R1 can go outside of the facility on pass, V7 stated, "No, (R1) can't go on pass with bracelet (electronic monitoring safety device) on." On 9/19/23 at 2:50 pm, V8 (CNA) stated that V8 was R1's assigned CNA on 9/12/23 from 7:00 am to 3:00 pm. V8 stated, V8 is familiar with R1 and R1 is alert and oriented x 1 (person). V8 stated, R1 was added to the Elopement Risk list when R1 was admitted and V8 checks the Elopement Risk list daily because it can be updated. V8 stated, V8 checks the (electronic monitoring safety devices) of the Elopement Risk list residents on the 3rd floor to "make sure it's there and if it's blinking." V8 stated, V8 does rounds every 2 hours at 7:00 am, 9:00 am, 11:00 am and 1:00 pm. V8 stated, "I (V8) fill out the (rounds) paper. If I can't find them, they (residents) may be out on pass or downstairs or on the patio. I check each room. If I don't see the resident, I would ask the other CNA on the floor. Sometimes the resident went out to the hospital or is on the patio. "Surveyor asked how does V8 know if resident is on the patio, V8 stated, "We (CNAs) go to the patio to check and would tell the nurse that we can't find the resident" if the resident is not on the patio. When asked about R1's activity during the day shift on 9/12/23, V8 stated V8 redirected R1. R1 would be sitting in a chair in the hallway by the nurse's station and then R1 would walk into the day room, followed by walking to the opposite hallway on the floor and then into R1's room. V8 stated, V8 checked	S9999		

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R1's (electronic monitoring safety device) on R1's ankle on the morning on 9/12/23 and that it was blinking. V8 stated, "I (V8) served (R1) lunch. (R1) came and sat down" in the dining room. Surveyor asked what time was the last rounds V8 performed to check on R1 on 9/12/23. V8 stated, "(V7) did the last CNA rounds around 2:30 pm." When asked when the last time V8 saw R1 on 9/12/23. V8 stated, "It was 1:00 pm, and (R1) was sleeping. V8 stated, (R1) speaks little English with using a few words to communicate in English. V8 stated, R1 would tell V8 that V8 wants to go out of the building, and V8 would instruct R1 to tell social services staff who will talk to R1.

Facility document (undated and received from the facility on 9/19/23) titled "Elopement Risk" documents, in part, the photos, names, gender, race, and height of 16 residents: R1, R3, R4, R6, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, and R20.

In R1's Progress Note, dated 8/18/23 at 8:29 pm, V32 (Licensed Practical Nurse, LPN) documents, in part, R1 is alert and oriented x 2 to self and place, verbally responsive, and "(R1) is not fluent in English, occasionally uses gestures to communicate with staff."

On 9/20/23 at 11:50 am, V3 (RN) stated, V3 floats to different floors in the facility and works the 7:00 am to 3:00 pm shift or the 3:00 pm to 11:00 pm shift. Surveyor asked how does V3 know who the elopement risk residents are where V3 is working. V3 stated, "I (V3) know by their (electronic monitoring safety devices), and the list of picture faces at the nurse's station. I check it, and I know them. Their faces. I check it at the beginning of the shift." Surveyor asked if a

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resident has an electronic monitoring safety device, what are V3's responsibilities as the charge nurse on the floor. V3 stated, "For me to do rounds and make sure that the (electronic monitoring safety device) are on. Check on their leg to see if it's on. Most of the time, it blinks red." V3 stated, when the electronic monitoring safety device is blinking red, it's working and V3 also checks the residents' skin integrity under the bracelet. When asked how often V3 perform resident rounds, V3 stated, "At the beginning of my shift and end of my shift." When asked who does rounds in middle of V3's shift, V3 stated, "Most of the times, the CNAs do." When asked how does V3 know who can go out of the facility and with what type of community pass, V3 stated, "Family and CNA will come take (residents) out on pass. Residents can go out on individual pass. I (V3) know, if not on (electronic monitoring safety device), then they can take the individual pass. Resident has to tell me (to go out on individual pass), and I have to sign the pass." V3 stated, on 9/12/23 for the 3:00 pm to 11:00 pm shift, V3 was assigned as R1's nurse and V3 was the charge nurse (only one nurse) for the 3rd floor. V3 stated, V3 was not familiar with R1 and had worked as R1's nurse one shift prior to 9/12/23. V3 stated, the 3rd floor CNAs who regularly work there are familiar with R1. V3 stated, on 9/12/23, "I (V3) came in late because I had to go and pick up my kids from school and came in around 3:30 pm. (V6, RN) was ready to leave." V3 stated, "(V6) gave me report. (V6) said a resident was out on pass, (R5)". When asked if any other resident was reported by V6 to be out on pass from the 3rd floor on 9/12/23, 3:00 pm to 11:00 pm, V3 stated, "No." When asked what did V3 do after nursing report, V3 stated, "I (V3) went to do rounds. I noticed most residents on the 3rd floor don't stay. Most of the time, I work on the 2nd

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floor. Most (2nd floor residents) are bed bound or sit in the day room. On 3rd floor, they move from one floor to another. They be on the 1st floor activities or on smoke break. Wander around building. 50% or more (3rd floor residents) are not in the (3rd floor) day room. Some residents are in (3rd floor) day room or downstairs doing activity." When asked where was R1 on V3's initial rounds on 9/12/23, V3 stated, "(R1). I (V3) didn't see (R1) in (R1's) room. I assumed, maybe, (R1) was in day room or walking. (R1) was not in the day room, so I assumed (R1's) downstairs on 1st floor doing activities." When asked did V3 call downstairs to the 1st floor to verify R1's location, V3 stated, "No, I (V3) did not call downstairs. They (residents) come back themselves to the floor when it's time to eat." Surveyor asked when it was time to eat dinner on 9/12/23, did R1 come back to the 3rd floor? V3 stated, "I (V3) was busy with an admission. I didn't notice (R1). There's one nurse on the floor. I have a lot of responsibility. I was so busy, and the admission came early. That day, I left late. I left the facility late from the admission. The CNAs are the ones that pass trays. CNAs are supposed to let me know what percentage of food they (residents) eat." V3 stated, V10 (CNA) or V11 (CNA) who were working on 9/12/23 from 3:00 pm to 11:00 pm did not report to V3 that R1 did not eat dinner on 9/12/23. V3 stated, when V18 (CNA) for the night shift "came and told me (V3), (R1) is not in bed. I was like, 'Come on.' My CNA (V10) didn't tell me." V3 stated, "When I (V3) came in (for the 3-11 pm shift), I was doing rounds. (V6) told me that (R5) was out on pass. When I went to pass meds, I saw (R5) in (R5's) bed. (R5) said (R5) was fine. (R5) said, 'I don't want my meds,' but I give (R5) the meds. I saw (R5). This is (R5). So was (V6) trying to tell me it was (R1) out on pass. I can't assume that a resident just walked out of

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the building not being noticed with security downstairs. Is (V6) trying to say (R1) instead of (R5)?" Surveyor asked how did V3 clarify which resident was out on pass on 9/12/23. V3 stated, "When I (V3) called (V6) and confirmed that it was (R5). I called (V6) at home. Time was late in the night. After 11:00 pm at end of the shift." When asked did R1 go out on pass on 9/12/23, V3 stated, "(V6) confirmed it was (R5) and not (R1) who was out on pass."

V3 stated, V18 (CNA) came early for the 9/12/23 11:00 pm to 7:00 am shift and informed V3 that R1 was not in R1's bed. V3 stated, this was before 11:00 pm and V4 (LPN) who was the night shift nurse had not arrived yet to the facility. Surveyor asked what did V3 do when V3 confirmed that R1 was not in facility and not out on pass. V3 stated, "I (V3) called (V2, DON). (V2) said, 'Oh, let me call you back. Let me call (V1, Administrator).' I had told (V2) that I assumed that (R1) was out on pass. (V2) said (R1) is not on individual pass to go out. I thought then that maybe family came into get (R1)." When asked did V3 speak to V2 after the first phone call with V2, V3 stated, "No. (V2) called back to (V4) who was there. (V2) did not call me back at facility. (V2) called me the next morning at home, and (V2) said (V1) wanted to talk to me. (V1) asked me questions. (V1) told me to come in. I was off on Wednesday (9/13/23). I come to (facility). I write a statement. I went in." This surveyor read statement V3's authored statement and asked if when V3 wrote "a resident," was this (R5), and V3 said "Yes. I (V3) assumed (R5) was (R1)." When this surveyor read V3's authored progress note (9/12/23 at 11:56 pm), this surveyor asked V3 if V3 was informed at or before 11:00 pm by V18 (night CNA) that R1 was not in R1's bed, why was V3 documenting that R1 was still out on pass 1

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hour later? V3 stated, "That's why I (V3) left the building late. I was doing admission. I lost track of time. It was late charting documenting. I was busy with my admission. I didn't sign it (note) until end of shift." V3 stated, V3 didn't sign the authored progress note initially because V3 wasn't sure if R1 was out on pass, and "That's when I (V3) called (V6). Was it (R5) or (R1)?" V3 checked V3's personal phone and stated, V3 phoned V6 on 9/13/23 at 12:01 am. V3 stated, "I (V3) called (V6). I am thinking (R1) is still out on pass at 11:56 pm. I was busy with my admission." When asked if V3 performed resident rounds at the end of 9/12/23 3:00 pm to 11:00 pm shift, V3 stated, V18 had started the rounds before V3 and V18 said R1 was not there. V18 stated, V10 (CNA) had already left the facility at that time. V3 stated, "I (V3) didn't see (R1) at all (on 9/12/23) when I did rounds. I am not going to lie. I didn't see (R1)." V3 stated, when V3 completed V3's 3:00 pm to 11:00 pm shift on 9/12/23, V3 left the facility and that the "Code Green was not called yet."

In R1's Progress Note, dated 9/12/23 at 11:56 pm, V3 (RN) documents, "(R1) remains out on pass."

V3's signed witness statement for V3's 3:00 pm to 11:00 pm shift on 9/12/23 documents, "When I (V3) came in for my shift, I realized (R1) was not in (R1's) room. (V6, RN) reported to me that a resident (R5) was out on pass. So, I assumed (R1) was out on pass."

R1's Physician's Orders Statement (POS) documents, in part, the following orders dated 8/21/23: "(R1) may wear (electronic monitoring safety device) for elopement precautions" and "Check (electronic monitoring safety device)

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placement/function/skin integrity q (every) shift." R1's POS (printed 9/19/23) does not contain an order for community pass privileges.

R1's Treatment Administration Record (TAR), dated September 2023, documents, in part, for the order of "Check (electronic monitoring safety device) placement/function/skin integrity q shift" on 9/12/23 for the 3:00 pm to 11:00 pm shift, V3 did not complete (not performed) this order for the documented reason of "Out on Pass."

On 9/21/23 at 3:52 pm, V6 (RN) stated, on 9/12/23, V6 did give verbal shift to shift nursing report to the oncoming nurse, V3, and updated the 24-hour nursing report in the electronic medical record (EMR). V6 stated it's a standard of practice to report residents who are on 72-hour monitoring, residents who are out on pass, or if there were incidents during the shift. V6 stated, "I (V6) gave report to (V3) and told (V3) that (R5) was the first time out to the community so watch for (R5) and monitor (R5) when (R5) comes back." V6 stated V6 gave report to V3 around 3:45 pm on 9/12/23 because V3 came late to work. V6 stated, "I (V6) didn't leave. I have to wait." V6 stated, when residents return from independent pass, staff does rounds to make sure that residents are back. V6 stated, R5 went out on pass around 2:00 to 2:30 pm on 9/12/23 and didn't return to the facility before V6 left the floor. V6 stated, from 3:00 pm to 3:45 pm, V6 was in the nurse's station and received no other information from CNA staff about R1 or R5's whereabouts. V6 stated, V6 communicated with V2 (DON) at 12 midnight on 9/13/23, "it was a sudden call, so I (V6) picked it up." V6 stated, V2 asked V6 about R1 or R5 being out on pass, and V6 told V2 it was R5. It was R5's first time out on pass and V6 put it in the 24-hour sheet and

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physically told V3, 'watch for (R5).' V6 stated, V2 said 'Okay' and asked if V6 did rounds when V6 was leaving the shift to see R1. V6 said "No, but (V6) saw (R1) that day." Surveyor asked if V6 communicated with V3 that night (9/12/13). V6 stated, "When (V2) called me, I (V6) was not at ease. I called (V3) to see what happened on (V3's) shift. (V3) stated (V3) mixed (R5) and (R1)."

Facility document dated 9/12/23 and titled "Community Pass Sign In/Out," documents, in part, R5 was out on pass from 2:30 pm (out-time) to 3:15 pm (in-time) on 9/12/23 with R5's printed name and signature noted. R1's name/signature is not documented on this 9/12/23 "Community Pass Sign In/Out" document.

R5's "Out on Pass" Assessment, completed on 9/4/23, documents, in part, that R5's pass level determination is "independent."

On 9/20/23 at 1:04 pm, V10 (CNA) stated, V10 worked the 3:00 pm to 11:00 pm shift on 9/12/23 on the 3rd floor and was assigned as R1's CNA. V10 stated, V10 came to work on 9/12/23 around 2:50 pm and started room to room rounds. V10 stated, around 3:00 to 3:10 pm, V10 checked in R1's room, and R1 was not there. V10 stated, V10 looked around the 3rd floor and in other rooms and didn't see R1. V10 stated, "By that time, residents want to eat. I (V10) didn't see (R1) before dinner. If (R1) want to come back. I keep the food. This is (R1's) food." [sic]. When asked on 9/12/23 at 3:00 pm to 3:10 pm, did V10 tell a nurse that R1 was not on the floor, V10 stated, "Nurse wasn't here. I didn't see a nurse. The food comes, (R1) did not come. I didn't see (R1). I keep (R1's) tray. (R1) assigned to me." [sic] V10 stated when V10 started V10's shift on 9/12/23,

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V3 (RN) was not there on the floor. V10 stated, at 4:00 pm, all residents come to the dining/day room to watch television and get ready for the dinner meal. V10 stated, "(R1) didn't come." When asked if V10 informed V3 at 4:00 pm R1 was not on the floor, V10 stated, "(V3) goes around, make their rounds. 4 pm rounds are for the nurse." V10 stated, V10's next resident rounds are at 5:00 pm, and "5 pm is for trays. I (V10) don't see (R1) in dining room. I tell (V3, RN). I tell (V3) that (R1) didn't come. I tell (V3) that I didn't see (R1)." When asked what time V10 told V3, V10 stated, "I (V10) tell (V3) I didn't see (R1) and that this is (R1's) dinner. I keep the food. 7 pm, time to pack up the trays. (R1's) tray is at nurse's station. I put it (R1's uneaten tray) in tray to go. Everyone eat their food except (R1), and I put all the trays back. (R1's) tray is the only one not eaten." V10 stated, on 9/12/23 at 7:00 pm, V10 informed V3 that R1 did not eat R1's tray and V10 did not see R1. V10 stated, on 9/12/23 at 8:00 pm, V10 went to do rounds and "clean the residents. I packed the trays and then change everybody. I didn't see (R1)." When asked when was the last time V10 checked in R1's room on 9/12/23, V10 stated it was at 10:00 pm and V10 did not see R1. Surveyor asked if V10 told V3 at 10:00 pm R1 was not in R1's room. V10 stated, "I (V10) didn't tell (V3) again because (V3) knows. (V3) knew. I leave at 11 pm. At 10 pm, I did rounds. Everyone was there except for (R1)." V10 stated, V10 knows R1 is confused and walks around the building. Surveyor asked V10 if R1 is an elopement risk resident. V10 did not answer the question. When asked which residents are at risk for elopement, V10 stated, CNAs do rounds on the 1st, 2nd, and 3rd floors. When asked when V10 arrived on the 3rd floor on 9/12/23 at 2:50 pm for V10's shift, how did V10 know who the residents are who wander or are trying to exit

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the building (elope), V10 stated, "I don't know." When this surveyor stated, R1 was an elopement risk resident, V10 stated, "I didn't know that." This surveyor read V10 the authored witness statement for V10, and V10 verified that it was V10's statement for the 9/12/23 shift despite V10 dating the witness statement as 9/5/23.

V10's signed witness statement for V10's 3:00 pm to 11:00 pm shift on 9/12/23 documents, in part, "I (V10) came in for my shift, I made rounds. Found out that (R1) was not in room. I thought maybe (R1) was still in the building. I indicated 'out' on the round sheet so (before) dinner and after dinner, (R1) was still not around, so I keep the food and alert (V3, RN)."

CNA Assignment Sheet dated 9/12/23 for the 3:00 pm to 11:00 pm shift documents, in part, V10 was assigned as R1's CNA.

On 9/20/21 at 1:40 pm, V11 (CNA) stated V11 floats to different floors and works the 3:00 pm to 11:00 pm shift. V11 stated V11 worked on the 3rd floor on 9/12/23 from 3:00 pm to 11:00 pm and was not assigned as R1's specific CNA "on that faithful day." V11 stated, V11 came to the floor around 3:15 pm on 9/12/23, and "(V10) did first rounds. I didn't do rounds first because I usually confirm my place. (V10) did overall rounds. (V10's) permanent there. (V10) knows the residents." V11 stated, "I (V11) didn't work with (R1) that day" but V11 remembers R1 from a previous shift. When asked on 9/12/23, did V11 see R1 in the building, V11 stated, "I (V11) didn't notice (R1). (R1) is not on my side. I am concentrating on the people who I am assigned to. That day, I am assigned to side B." V11 stated, V10 was on side A hallway on the 3rd floor and V11 was "concentrating on the B side."

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S9999	Continued From page 15 Surveyor asked how does V11 know who the elopement risk residents are. V11 stated, "They have something on their leg. Person can alarm that someone is leaving the building. I can go to nurse's station (to see the elopement risk list) with name of residents that something's on their leg." When asked if V11 checked the posted elopement risk on 9/12/23, V11 stated, "Yes. I (V11) did look at it on my 3 to 11 (shift). I was on B side. Just when I walk in, then I will check names. They have (electronic monitoring safety devices) on them. I only look at the residents assigned to me." V11 stated, "I (V11) do rounds every 2 hours. I fill out the (rounds) sheet." When asked if V11 communicated with V10 during the 9/12/23 3:00 pm- 11:00 pm shift about R1 not being on the floor, V11 stated, "I (V11) only face my area where I am working." Facility document titled "Resident Hourly Checklist" and dated 9/12/23, documents, in part, that on the 7:00 am to 3:00 pm shift, R1's last documented observation is at 1:00 pm with an "S" documented for "sleeping." V6 (RN), V7 (CNA), and V8 (CNA) are the staff verifying the resident hourly checklist for the 7:00 am to 3:00 pm shift. For the 3:00 pm to 11:00 pm shift, R1 is documented as "O" indicating "Off unit check with Receptionist/Social Services" for 3:00 pm, 5:00 pm, 7:00 pm, and 9:00 pm. The lines of "Staff Verifying Form" and "Name of Nurse on shift" from the 3:00 pm to 11:00 pm shift is blank with no documentation. Daily Nursing Schedule dated 9/12/23 documents, in part, that on the 3rd floor, for the 7:00 am to 3:00 pm shift, V6 (RN), V7 (CNA), and V8 (CNA) are assigned; for the 3:00 pm to 11:00 pm shift, V3 (LPN), V10 (CNA), and V11 (CNA) are assigned; and for the 11:00 pm to 7:00 am	S9999		

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shift, V4 (LPN), V18 (CNA) and V30 (CNA) are assigned.

On 9/21/23 at 3:34 pm, V4 (Licensed Practical Nurse, LPN) stated, V4 works primarily on the 3rd floor on the 7:00 am to 3:00 pm and 11:00 pm to 7:00 am shift and V4 worked on 9/12/23 from 11:00 pm to 7:00 am. V4 stated, V4 is familiar with R1 and that R1 is alert, oriented and R1 will "exercise and will walk around." V4 stated, V4 had brief conversations with R1 with R1 saying "Hi." V4 stated when V4 arrived on 9/12/23 for the 11pm-7am shift, V4 did V4's rounds to go around to all residents, and V4 did not see R1. V4 stated, "I (V4) went right away to (V3) and asked, 'What happened? (R1's) not here' and (V3) said, '(R1's) not in the building. (R1's) out on pass.' V4 stated V4 informed V3 that R1 doesn't have pass privileges to be out on pass, and V4 asked V3 if V3 reported this to V2 (DON) or if V3 was "doing something about it." V4 stated, V4 knows R1 should not be out on pass and then called V2 to report R1 was missing. V4 stated, V4 then called a Code Green overhead and staff working checked the 2nd and 3rd floors and the patios and by the exit doors. V4 stated, V4 called back V2 on the phone to report R1 was missing, and V4 called 911 to file a missing person report. V4 stated, V4 arrived to work on 9/12/23 around "11 something." V4 stated, it was 10 minutes after 11:00 pm and by that time, the CNA (V18) had already gone around on V18's rounds where R1 was not present. When asked what a nurse or CNA does when they normally do rounds, V4 stated, "We go around to every residents room to make sure that they are awake, alert and to account for all residents and that no one is missing." V4 said, since V4 came in a little late to work, V4 did V4's tour of the floor, "going room to room to check that everyone is present, and I

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(V4) did not see (R1) in bed." V4 stated, V3 told V4 that R1 was out on pass, and "I (V4) know (R1) does not have pass privileges." V4 stated, V4 asked V3 while still at the nurse's station, "Did you (V3) report to (V2, DON)? Even if (R1's) out on pass, it's past 8:00 pm, and (R1's) not back." V4 stated, if a resident who is out on pass has not returned to the facility by 8:00 pm, nurses are to report to V2 and the physician. V4 stated, V3 kept saying, "(R1's) out on pass." V4 said, V4 reported to V2 what V3 said and a Code Green was called overhead. V4 stated, all staff came to the floor, and staff searched all over the facility. V4 stated, head counts were done of residents on 1st, 2nd, and 3rd floors. V4 stated, some staff went outside the facility to search for R1. V4 stated, after the search for R1, an officer from the local police department came to the facility where V4 provided R1's description of R1 and R1's picture.

This surveyor read V4's progress note, dated 9/13/23 at 12:44 am. When asked if R1 was wearing an electronic monitoring safety device, V4 stated, "Yes." When asked why R1 was wearing an electronic monitoring safety device, V4 stated, "(R1's) an elopement risk. It's on (R1's) POS. (R1's) on the (electronic monitoring safety device) list posted at the nurse's station." V4 stated, R1 had an electronic monitoring safety device and was not to be out on pass.

In R1's Progress Note, dated 9/13/23 at 12:44 am, V4 documents, in part, "(V4) received endorsement from (V3) stating (R1) was out on pass, @ (at) 12:09am, (V4) notified (V2, DON) that (R1) had not returned from pass, at which time (V2) said (V2) was not aware (R1) was out on pass. (V2) instruct (V4) to initiate A CODE GREEN. Conducted head count on all unit. (R1) was not accounted for. Facility thoroughly

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searched both inside and outside and surrounding vicinity of facility searched thoroughly for up to 2 miles. (R1) is responsible for self. (V28, Attending Physician) and (V31, Psychiatrist) notified. (V1, Administrator) notified. Called (Call) placed to surrounding hospital to alert them. Missing person report filed with the (local police department) with (police report number), copied of Face sheet and picture given to (local police department)."

V4's signed witness statement for V4's 11:00 pm to 7:00 am shift on 9/12/23 documents, "At 11:00 pm, during rounds for the beginning of the shift, (R1) was not in the unit. (V3, RN) told me (V4) that (R1) is out on pass. (R1) is on supervised pass privileges. (V2, DON) notified. Code Green initiated. Resident head count conducted. (R1) no accounted. Missing person report filed with (local police department)."

On 9/25/23 at 3:54 pm, V18 (CNA) stated, V18 floats to all 3 floors and works the 11:00 pm to 7:00 am shift. V18 stated, V18 is familiar with R1. When asked on 9/12/23 for the assigned 11:00 pm to 7:00 am shift, what time did V18 arrive, V18 stated, "When I (V18) came to work, I remember it was 10:30 to 11:00 pm. I go to the rooms and check everywhere to see that my residents are intact, and I discover that (R1's) not on (R1's) bed. I got (V3, RN) and say [sic], 'I did not see (R1) on bed.' (V3) said, 'According to (V5), (R1) is out on pass.'" When asked if V18 informed any other staff that R1 wasn't present in the facility on 9/12/23, V18 stated, V18 told V4 that V18 did not see R1. V18 stated, staff tried to find R1 with a Code Green being called in the facility. V18 stated, R1 did not return to the facility at 7:00 am when the shift ended.

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On 9/20/23 at 10:58 am, V13 (Receptionist) stated, V13 works Monday through Friday from 8:00 am to 4:30 pm and V13 was working on 9/12/23. V13 stated, "I (V13) am responsible for keeping my eyes on the door, who's coming in and out, though I do man the fax machine and make copies of doctors' orders. Anyone who is coming into the bay area. (Front lobby)." V13 stated, the front door at the entrance of the facility is locked. When asked how residents, staff or visitors are to leave the facility from the front door, V13 stated, "I (V13) have to buzz them out." V13 pointed to the buzzer button that is on top of V13's office desk. V13 stated, "I (V13) have to confirm their identity to buzz them out. I make sure I learn their (residents) name and learn their face. I question them when (they are) new admissions until I am more familiar." When asked how V13 sees the person at the front door in V13's sitting position behind the walled off desk and window, V13 stated, "I (V13) monitor from side to side. Getting up out from my desk is the secret of secretary." (V13 then leaned over in V13's chair at a 45-degree angle, side to side, to demonstrate how V13 can see to the front door beyond a wall pillar that is partially blocking V13's view). When asked how V13 knows who the elopement risk residents are, V13 pointed to the elopement risk list posted on the upper wall next to V13's computer station. V13 stated, "I check and ask questions of the (electronic monitoring safety device) residents. If they go towards the door, the (electronic monitoring safety device) will beep. That's the time to get up. I address the alarm. I never know if it's a new resident." When asked how often V13 checks the elopement risk list, V13 stated, "Often. I'm checking it constantly. It can change." When asked about the video camera monitor at V13's desk with 7 separate camera views of facility exits, basement hallways,

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and outside patio area, V13 stated, "I (V13) monitor it. It tracks each of the different areas. Outside areas. We can see what's going on. I look at front door, buzz them in and out. See the back gate. Basement halls, can see both views." When asked about the outdoor patio fence door, which is an emergency exit, V13 stated, "I (V13) can hear it. The patio. It will alert us to check these things. Different sounds of alarms. Emergency sounds." When asked if V13 is familiar with R1, V13 stated, "I (V13) saw (R1) several times. Two times (R1) attempts to go out. [sic] When I did see (R1) (on 8/21/23 during R1's first elopement), I didn't know (R1). I hadn't seen (R1) before, but (R1) was a resident. They (staff) spoke to (R1) and were able to guide (R1) back. (R1) asked for a pass to go out (on 9/12/23). I told (R1) that (R1) has to go to social services. Told (R1) where it's located." When asked if V13 encountered R1 on 9/12/23, V13 stated, "Yes. (R1) was in the lobby. Approximately 2:00 to 3:00 pm. I (V13) go to lunch break from 1:00 to 2:00 pm, and it was after I came back. (R1) was standing here in the office (at the counter at V13's desk). (R1) was asking for a pass to go outside. I told (R1) to go to social services. Go downstairs to get the pass. (R1) said that no one was down there. I told (R1) to try again." V13 stated, V13 verbally redirected R1 from the front lobby and that R1 went back into the 1st floor to go downstairs. V13 stated, V13 did not see R1 in the front lobby from 2:30 pm to 4:30 pm on 9/12/23. When asked if V13 saw R1 on the camera monitor leaving the facility at any exit in the facility (front door, basement emergency exit door, or patio emergency exit door), V13 stated, "No. From 2:30 to 4:30 pm, I (V13) did not see (R1). At 3:00 pm, security comes to the front door and will watch the door." V13 stated, when residents are going out on a day pass, they must sign out in the

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"Sign In/Out" logbook on the other side of the glass window in front of V13's office, and they must show V13 the paper pass with the two staff signatures (nurse and social services) and the date. When asked if the electronic monitoring safety device alarm goes off at the front door, who responds, V13 stated, "I (V13) always do. I put the code in. When it's everyone here and the wheelchair residents are lined up for smoke breaks, it's (electronic monitoring safety device alarm) always going off." V13 stated, the electronic monitoring safety device alarm is activated when the electronic monitoring safety device residents walks in the "zone" in front of the front door.

On 9/20/23 at 11:10 am, V16 (Business Office Manager) is positioned in V16's desk directly behind V13's desk in the front office. V16 stated, V16 buzzes residents in and out of the front door of this facility and showed this surveyor the buzzer button on V16's desk. When asked if V16 can see residents (physically view) from V16' desk position, V16 stated, "I (V16) can't see honestly. I can see them (residents) walking past (pointing to the front lobby through glass office window), but they are already past. I get up and walk to see. I can't see them from the post in the way." When asked about seeing R1 on 9/12/23, V16 stated, "I (V16) didn't see (R1). I know (R1). I know (R1's) person." V16 stated, V16 takes a lunch break daily from 2:00 to 3:00 pm. V16 stated, "I didn't see (R1). I did not see (R1) walking in hallways." When asked about electronic monitoring safety device residents walking into the front lobby, V16 stated, "If buzzer (alarm) goes off, I (V16) go up to machine (key panel) and put in code." When asked on 9/12/23, did electronic monitoring safety device alarm system go off in the front lobby, V16 stated, "I

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(V16) probably didn't sit. I was getting up constantly to turn it off." V16 stated, smoke break times are at 1:00 pm and at 3:00 pm, and "it gets busy" in the front lobby.

On 9/20/23 at 4:12 pm, V12 (CNA/Security) stated, on 9/12/23 from 3:00 pm to 7:00 pm, V12 was working as a security at the table stationed at the front door of the facility. When asked V12's responsibilities, V12 stated to check for residents who are going out on pass to confirm they can go out. V12 stated, if residents are not allowed to go out on individual pass, I "tell them to go back." V12 stated, V12 knows who the elopement risk residents are from the posted elopement risk list. V12 stated, when the residents who wear the electronic monitoring safety devices come close to the front door, the alarm will go off. V12 stated, V12 then has to put in a code on the key panel to turn it off. V12 stated, after putting in the code on the key panel and the alarm continues to keep going off, then V12 has to "turn them back" more from the front lobby door and put in the code again to reset the alarm. V12 stated some electronic monitoring safety device residents in wheelchairs do go outside the front door to the front area where residents smoke but V12 is monitoring them. V12 stated, V12 stated on 9/12/23, V12 did not see R1 at the front door of the facility. When asked if R1 go out on community pass, V12 stated, "Not that I (V12) am aware." V12 stated, residents with the electronic monitoring safety devices can leave the facility only if they are escorted with a staff member from social services.

Facility document (undated) titled "Smoking Schedule," documents that Mondays through Fridays smoke times are at 9:00 am, 1:00 pm, 3:00 pm and 5:30 pm and that Saturdays and

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S9999	Continued From page 23 Sundays smoke times are 9:00 am, 1:00 pm and 3:00 pm. On 9/25/23 at 1:46 pm, V17 (Registered Nurse. RN) stated, V17 worked on 9/12/23 from 7:00 am to 3:00 pm as the charge nurse on the 1st floor. When asked about the 1st floor camera monitor at the nurse's station showing facility exits and basement hallways, what is V17's responsibility when working on the 1st floor, and V17 stated, "I (V17) look at the video if I am less busy at the nurse's station." V17 stated that when V17's not looking at the computer (electronic medical record) charting, V17 will look at the camera monitor. V17 stated that the elopement risk list is posted at the 1st floor nurse's station, and "We need extra eyes on them." When asked on 9/12/23 from 7:00 am to 3:00 pm, did V17 see R1 on 1st floor, and V17 stated, "No." When asked on 9/12/23 from 7:00 am to 3:00 pm, did V17 see R1 exiting the facility on the camera monitor at the 1st floor nurse's station, and V17 stated, "No." When asked does V17 receive calls from other floor staff asking about the location of residents, V17 stated, "Yes. Activities is in the (1st floor) dining room. They will call me (V17) to check the 1st floor room when they want them (residents) to come back up." Surveyor asked V17 on 9/12/23 at 3:00 pm, did V17 receive a call about the whereabouts of R1. V17 stated, "No." On 9/25/23 at 1:53 pm, V20 (Social Services/Smoke Monitor) observed standing in 1st floor hallway facing towards front entrance door and to V20's left side is the short hallway leading towards smoking patio door. V20 stated, V20 monitors the smoking patio (outside the facility) and watches the hallway crowd on the 1st floor. V20 stated the door (west side of building) leading to the smoking patio is not locked and	S9999		

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that anyone can open it. V20 stated the smoking breaks are at 9:00 am, 1:00 pm, 3:00 pm and 5:30 pm, but that residents can go out to the patio to get fresh air. V20 stated V20 does not watch the front entrance door in the lobby because that's the receptionist's responsibility. V20 stated V20 works on Mondays through Fridays from 10:00 am to 3:00 pm, and V20 stated, "I am here (at post). I can see to front door." V20 stated, V20 stays close to V20's post in the hallway especially with smoking times, and "I (V20) can see movement (of residents) easy." V20 stated, residents wearing electronic monitoring safety devices are not allowed to stay in the front lobby and V20 will assist moving these residents back into the 1st floor hallway. When asked on 9/12/23 if V20 saw R1 on the smoking patio or in the 1st floor hallway, V20 stated, V20 doesn't know who R1 is. This surveyor and V20 then walked to the posted Elopement Risk list at the 1st floor nurses station with R1's picture/information still present on the list. This surveyor pointed to R1, and V20 stated, V20 does not recognize R1. V20 stated, R1 is not a smoker, and V20 did not see R1 in the 1st floor hallway. This surveyor informed V20 that R1 was admitted to the facility in August 2023, and V20 stated, "That's why I (V20) don't know (R1). I don't know (R1) until I start seeing (R1)." When asked on 9/12/23 around 2:30 pm, did V20 see R1 on 1st floor hallway, V20 stated, "No. I (V20) go to the receptionist at that time." V20 stated, R1 never went out to the smoking patio. When asked what's the Elopement Risk list signify, V20 stated, "More people we are concerned to look after more." When asked how often does V20 check the Elopement Risk list, V20 said, V20 checks it on Fridays. V20 said, "You (this surveyor) even said that (R1) was a new resident. That's why I (V20) am not familiar with (R1)."

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R1's hospital records from an admission on 8/11/23 to 8/18/23 document, in part, R1 had attempted to elope from another long-term care facility with aggressive behavior.

Facility document titled "New Referral Verification Checklist" documents, in part, R1's "date of expected admission" of 8/18/23 with "special equipment needs: elopement precautions."

On 9/21/23 at 2:07 pm, V5 (Assistant Social Services Director) stated, V5 and V9 (Social Services Director) perform the cognition, elopement risk, out on pass, social history, and discharge assessments for new admissions, readmission, quarterly and when needed. V5 stated, V5 initiated R1's cognition, elopement risk, out on pass, social history and discharge assessments on 8/21/23 after R5 was admitted to the facility on 8/18/23. V5 stated, if a resident scores as high risk for the elopement risk questions, then interventions like a safety alarm (electronic monitoring safety device), therapeutic group meetings and recreational activities can be used. When asked how staff are made aware of elopement risk residents, V5 stated, "Staff are aware. Face sheet pictures are posted (on elopement risk list). We discuss with IDT (intradisciplinary team) in the morning meetings, and they will alert their staff." V5 stated, V5 assessed R1's cognition with a BIMS score of 6 (severe cognitive impairment). V5 stated, R1 had a history of eloping from a former facility. V5 stated, V5 must look at "behaviors and cognition and historical" levels when doing admission assessments. When asked what behaviors did R1 exhibit, V5 stated, "Wandering. (R1) did show exit seeking." V5 stated, with R1's cognition being "at the lower end," R1's wandering in the facility

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could mean he's looking for activities. V5 stated, "Behavior is an expression of something the resident may not be able to verbally communicate." When asked about V5 conducting R1's social history, V5 stated, "Communication, it was a little bit difficult. I (V5) was using my phone (to translate). That's the best way. (R1) had a language barrier. (R1 was) not very attentive. (R1's) long term memory was good, not (R1's) short term. I had to turn (R1) around during interview. (R1) did speak in English, but it was remedial. It was broken English. (R1) was not clear on last year. (R1) was not able to keep (R1's) focus." V5 stated for R1's out on pass assessment, V5 stated, "(R1) is not oriented x 3. When I (V5) did (R1's) assessment, (R1's) BIMS is 6. The first question (on the 'Out on Pass' assessment) is if the resident is oriented x 3, and I marked no. On the assessment, then you have to skip to the 2nd part. This automatically put (R1) as supervised pass. Plus, (R1's) elopement risk." V5 stated, for an independent pass, the resident can't be oriented x 2. V5 stated, "Resident must be more oriented for independent pass, and independent pass would nullify elopement risk." V5 stated, for an individual pass, "Resident is deemed safe to be in the community on their own, have decisional awareness and insight and make decent decisions." V5 stated, the daily time frame for residents to go out on pass to the community is from 9:00 am to 8:00 pm. V5 stated, social services and nursing staff must sign the independent pass paper for a resident to leave the facility to go out to the community. V5 stated, "(R1) is not on an independent pass." V5 stated, for R1's supervised pass level, "Staff must be with (R1)." V5 stated, for a supervised pass with a family member or friend, the family member or friend is to with the nurse to sign that resident out of the facility. When asked if R1 had

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an elopement prior to 9/12/23, V5 stated, "(R1) attempted and was redirected. I (V5) was made aware. (R1) was in the front lobby. Code Green was called. (R1) stepped out the front door. There were a lot of residents there. (R7) was being discharged. It was commotion in the front. We were there for a discharge." V5 stated that more residents were present in the front lobby for smoke break around 9:00 am. When asked if V5 was present when R1 eloped on 8/21/23, V5 stated, "Yes. I (V5) was present. It was soon after (R1) was admitted. On 8/21/23 morning. The end of 72-hour monitoring, we were coming up to it. (R1) was admitted on Friday afternoon (8/18/23)." V5 stated, "Because of it (elopement), I met with (R1) immediately to do (R1's) assessment to have everything in place." V5 stated, on 8/21/23, V5 did not see R1 exit out of the facility's front door because V5 had stepped away from the front lobby to retrieve R7's belongings list on the 3rd floor. V5 stated, when V5 was coming back downstairs to the first floor, V5 heard the Code Green called on the overhead paging system. V5 stated, V5 ran to the front lobby and asked V13 (Receptionist) about the Code Green resident, and V13 said, "It's the new admission." V5 stated, "I (V5) knew then it was (R1). We (staff) were all going after (R1)." When asked if R1 was able to make it off the facility property, V5 stated, "Yes." When asked on 8/21/23, was R1 able to leave the facility unsupervised, V5 stated, "No, (R1) was not able to leave the facility." V5 stated, on 8/21/23, V5 stated, "We got an (electronic monitoring safety device) order from (V28, Attending Physician)." V5 stated, the electronic monitoring safety devices and the "machine" to activate the electronic monitoring safety device (tag) before placing it on the resident. V5 stated, V5 makes sure that the electronic monitoring safety device (tag) is blinking and will also walk

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with the electronic monitoring safety device (tag) by the front door "a few times" to ensure that the alarm goes off. V5 stated, V5 will place the electronic monitoring safety device (tag) on a bracelet and place it on the resident's lower leg. V5 stated, on 8/21/23, V5 did this process with activating and applying R1's electronic monitoring safety device on R1's right ankle. When asked when V5 is retrieving the electronic monitoring safety device from V1's office, does V5 document on a form (facility policy reads "Residents with (electronic monitoring safety device)" form) of who has the electronic monitoring safety device, the serial number of the device or the placement location of the device, and V5 stated, "No. I (V5) don't document that or the serial number or the location." V5 stated, electronic monitoring safety devices are checked every shift by nursing staff to ensure that they are functioning. V5 stated, the electronic monitoring safety device alarms are located on the front entrance door and the basement door in the back of the facility. V5 stated, when V5 tests the functioning of the electronic monitoring safety device (tag) prior to applying it to a resident, V5 stated that the device will trigger the door alarm before V5 reaches the door. V5 stated, electronic monitoring safety device (tag) will turn from a blinking red color to straight red when it is triggered by the door alarm sensor. V5 stated, residents on the 1st and 3rd floors "are exit seeking residents. Staff is on high alert. Exit seeking residents are redirected. On the first floor, if (they are) near the door, we tell them to go by TV (television). Other residents in the room watching TV. It's not as hard for the resident to locate." When asked does V5 receive calls throughout V5's shifts from nurses or CNAs about a resident's location in the building, V5 stated, "Not often." On 9/12/23, did V5 receive a call from a nurse or CNA from the 3rd floor about

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S9999	Continued From page 29 R1's location, V5 stated, "I (V5) was not here. I can tell you that social services staff was not in the building. I was delayed." V5 stated, the socials services staff was at an education seminar outside the facility and V9 (SSD) came back to the facility sometime after 2:00 pm on 9/12/23. When asked if there is a video camera monitor in the social services office of the facility exits, V5 stated, the only camera monitors are at the 1st floor nurse's station, receptionist desk in front office and in V1's office. When asked who monitors the exits of the facility, V5 stated, "I am mostly in the social services office in the basement by where the basement door is. The smoking patio alarm is loud, and we can hear if anything is going on. Smoking monitor (V20) is watching the back two exits. We can hear an alarm." When asked did R1 smoke, V5 stated, "No. But (R1) can go out on patio." In R1's "Out on Pass" assessment, completed on 8/22/23, for the question of "Is the resident alert and oriented to time, place, and person (aox3)?" V5 documents, "No." This assessment indicates that if the answer to the orientation question is "No," then the assessor skips the remainder of the assessment and provides the resident with a supervised pass. R1's pass level determination is marked as "Supervised." In R1's "Social History and Assessment," completed on 8/23/23, V5 documents, in part, R1 speaks Mandarin and English language and that R1 does not have an emergency contact and does not speak to any family at this time. On 9/21/23 at 11:39 am, when asked if R1 had eloped any other time (than 9/12/23), V13 (Receptionist) stated, "Yes. Since (R1's) came here, (R1) always comes down, and I (V13) see	S9999		

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(R1) by the door and redirecting (R1) away. That's been the problem." V13 stated, it was on 8/21/23 when R1 first arrived. V13 stated, R1 came down to the first floor and was standing outside the lobby where the residents line up for smoke break, and "there was something going on." V13 stated, residents line up at 8:30 am for smoke break at 9:00 am, and "there were so many things going on that morning." V13 stated, the first time that V13 ever saw R1 was when V13 opened the door for "someone else (V26, R7's Family Member) to come in and somebody (R1) ran out." V13 stated, V13 notified staff, and they ran after R1. V13 stated, V13 was watching the door from V13's seated desk and opened the door and that it takes a couple of seconds for the door to slide closed "and that's when (R1) ran out." V13 stated, it was difficult for V13 to stop R1 with V13 being in the office behind the desk and tried to run after R1, but V13 called a code green where all staff responded. V13 stated V13 visually saw R1 exiting the facility on 8/21/23 and that R1 did not have an electronic monitoring safety device. When asked if V13 gets calls from nurses or CNAs in the facility about a resident's location, "Yes, I get calls here and there." When asked if V13 received a call from any staff on 9/12/23 about R1's location, V13 stated, "No."

On 9/26/23 at 11:02 am, V19 (CNA) stated, V19 was the assigned CNA to the 1st floor on 9/12/23 from 7:00 am to 3:00 pm. When asked on 9/12/23 during V19's shift on the 1st floor, did V19 see R1 on the 1st floor for activities or in the dining room with the TV, V19 stated, "I (V19) don't remember seeing (R1). (R1) stays on the 3rd floor." When asked with the camera monitor at the 1st floor nurses station, does V19 watch the facility exits, and V19 stated, "No." When asked if V19 if familiar with what R1 looks like,

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V19 stated, "Yes. The first time I (V19) saw (R1), (R1) tried to run away. We were done with breakfast, and I was in the dining room (on 1st floor) and heard (V13) at the desk say, 'Hey, hey.' So, I went to seeing what was going on, and I saw (R1) outside turning left on the street. (R1) went down to the next street and took a left. (R1) was running fast. I was running fast after (R1). (R1) ran to a building that had a gait, and it was locked. So, (R1) stopped. (R1) was breathing heavy. I said, 'STOP or I will call the police.' (R1) stopped and (V22) came up behind us and other staff came. (R1) walked back." When asked if R1 said anything when you caught up with R1, "(R1) didn't say anything." V19 stated, other residents from the 2nd and 3rd floors come down to the day room on the 1st floor and that "I really didn't see (R1) on the 1st floor." When asked if V19 received a call for from other staff inquiring where R1 was on 9/12/23, V19 stated, "No."

On 9/20/23 at 2:52 pm, V9 (SSD) stated, "Elopement risk assessment will indicate if resident can have an individual pass or not." V9 stated, when a resident is assessed at high risk for elopement, a physician order is required for the electronic monitoring safety device. V9 stated, V1 trained V9 on how to use the electronic monitoring safety device "machine" to activate the electronic monitoring safety device before applying it to the resident. When asked when V9 places the activated electronic monitoring safety device on the resident, does V9 document on a form/log of which electronic monitoring safety device is used (serial number) for which resident, and V9 stated, "I (V9) do not have a log of the sensor. I put it on the individual (resident). I don't have a log." V9 stated, CNAs monitor the electronic monitoring safety devices every shift to make sure that the red light on the sensor is

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blinking, and if it's not, then social services staff would be alerted. V9 stated, R1 was quiet, redirectable with no significant aggression, delusions or paranoia. When asked if R1 had exit seeking behavior, V9 stated, "Yes, (R1) did. (R1) left and was able to be redirected. (R1) came back into building." V9 confirmed, this was on 8/21/23. V9 stated, "When (R1) left, I (V9) was aware (of (R1) leaving). At that time, I was right around the corner. I was in the day room. (R1) left out the front door." When asked did R1 have an electronic monitoring safety device on at that time on 8/21/23, V9 stated, "I believe it was after that when (V5) did put it on (R1)." V9 stated, V9 responded to the Code Green for R1 on 8/21/23 and R1 was redirected back to the facility from down the street block. V9 stated, "Since (R1's) an elopement risk, (R1's) on a supervised pass. It's the standards. (R1) would have to be monitored with staff have to go out (of facility). With family as well." V9 stated, "Social services is responsible for maintaining the list for elopement risk. We update it with new admissions then update this. Make sure everyone who is on it, should be on it." When asked where the elopement risk list is posted, V9 stated, "One in the business office, one with (V2), and each nurse's station." When asked what the purpose of the elopement risk list is being posted, V9 stated, "Purpose so when staff walks by, (they can) be conscious of who have the (electronic monitoring safety device) on. Even if you are not the CNA, make sure that everyone is on the floor." V9 stated, the electronic monitoring safety device alarm system is at the front door of the facility; that when it is triggered, staff will put in a code in the key panel; and that the alarm will keep going off until the code is entered. When asked about the basement emergency exit door having an electronic monitoring safety device alarm system,

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V9 stated, it does "not have a (electronic monitoring safety device alarm) to my knowledge." When asked on 9/12/23, did V9 see R1 in the facility, and V9 stated, "No. I (V9) got back later in the afternoon. Around 2 pm. We had an in-service in our sister facility. All Social Services staff. When I came back, I went downstairs. I went to the 3rd floor. I don't remember seeing (R1)." V9 stated, V9 was informed of R1's elopement on 9/13/23 and that R1 is considered a missing person. V9 stated, "It is unknown to me (R1's) current location."

In R1's Progress Note, dated 8/21/23 at 5:07 pm, V9 (SSD) documented, in part, as a behavior note, "Code green was called for (R1) on this date. Staff was able to redirect consumer back to the facility with no issues or concerns ... Do (due) to this incident and (R1's) history, (R1) was counseled about the (electronic monitoring safety device). With (R1's) permission, a (electronic monitoring safety device) was placed on (R1's) ankle, TP (Treatment Plan) has been updated to reflect this change."

In R1's Progress Note, dated 8/21/23 at 9:40 am, V6 (RN) documents, in part, "At 8:25 am, (R1) noted to be highly exit seeking by attempting to leave the facility. Staff redirected with negative. Social services ... deem for elopement prevent program. (V28) aware with order for (electronic monitoring safety device), functioning (electronic monitoring safety device) placed on (R1's) right ankle. Staff will monitor skin integrity. (V2) notified. Will continue to monitor."

R1's Care Plan, dated 8/22/23, documents, in part, a focus of "Behavior symptoms: Elopement (Social Services). Due to symptoms related to (R1's) dx (diagnosis), (R1) can present as an

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elopement risk" with a goal of "(R1) will show decrease in episodes of elopement" and with interventions of "Ensure proper placement of ankle alert (electronic monitoring safety device) and check for any malfunction. Redirect negative behaviors. Document in the progress notes intensity, duration or frequency of behavior."

R1's Care Plan, dated 8/23/23, documents a focus of "(Electronic monitoring safety device) - Nursing: (R1) presents at an elevated risk for elopement related to dx of Schizophrenia and has been given a (electronic monitoring safety device) for safety" with a goal of "(R1) will be prevented from eloping from the facility" and with interventions of "Apply (electronic monitoring safety device) as ordered. Check (electronic monitoring safety device) and skin integrity q shift. Check (electronic monitoring safety device) band for malfunctioning as per facility policy. Monitor for episodes of elopement. Monitor skin under straps for signs of irritation and breakdown."

In R1's "Discharge Potential/Planning Evaluation," completed on 8/22/23, V9 (Social Services Director, SSD) documents, in part, R1's discharge status is a "nursing facility required to help the resident attain or maintain highest practical health status" with a note for R1 of "Due to (R1's) noncompliance with medication and limited symptom management skills, it would be benefit (for) (R1) at this time to reside in a closely monitored and supervised environment."

On 9/19/23 at 1:39 pm, when asked if R1 is in the facility, V1 (Administrator) stated, "No." When asked if V1 is aware of R1's current location, V1 stated, "No." When asked if V1 has viewed the facility's video camera footage from 9/12/23 when

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R1 eloped from the facility, V1 stated, "No." V1 stated, there is something wrong with video camera system, and "there's a black screen." V1 stated, "I (V1) am under the impression of a recording, and we are unable to access it." V1 stated, on 9/12/23 at approximately 3:00 pm, R1 eloped from the facility. When asked how did V1 confirm that R1 eloped from the facility on 9/12/23 at 3:00 pm, V1 stated, V1 is using the 3:00 pm timing because V1 "interviewed the staff during the 1st shift (7:00 am to 3:00 pm). Those staff members said (R1) ate breakfast, lunch and then was sleeping. They actually saw (R1). The 2nd shift nurse (V3, RN from 3:00 pm to 11:00 pm) did not see (R1). On rounds, (V3) did not see (R1) and thought (R1) was out on pass."

On 9/20/23 at 12:30 pm, V1 stated, V1 was not able to do a look back at previous video camera footage in the facility. V1 stated, "It's (video camera) operable now in real time. If I (V1) look at the monitors, I can see. The issue is with the recording part."

On 9/20/23 at 3:22 pm, V1 stated, V1 is familiar with R1 and that R1 was adjusting to facility. V1 stated, R1 was not social with other residents, and V1 "didn't really have too much conversation with (R1)." V1 stated, "(R1) walked around a lot in the facility." V1 stated, R1 was assessed when admitted as an elopement risk and V1 and managers in the facility are made aware of elopement risk residents during the IDT morning meetings. When asked what typical interventions for elopement risk residents are, V1 stated, "(Electronic monitoring safety device) is the most significant intervention. (R1) was okay with (electronic monitoring safety device), and social services put it on (R1). Other than that, is monitoring. Make sure everyone is aware (of the

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elopement risk residents). There's a short description at the nurse's stations. Dietary. Nursing. Every manager is aware to convey to their staff." When asked why it is important for all staff to know who is at for elopement, V1 stated, "So, everyone is on board. Down to the housekeeping staff. Residents can be in the basement. Trying to open doors. That way they know that this is not just another resident. A special resident who is elopement risk. This is the problem." V1 stated, "R1's elopement on 8/21/23, and care plan was updated. (Electronic monitoring safety device) initiated due to (R1) getting out." V1 stated, staff gets the electronic monitoring safety devices from V1. When asked does V1 keep an inventory list/form of the electronic monitoring safety devices being placed on residents, V1 stated, "No, not an inventory list. I (V1) know who has them. Nurse will cut it off. I switch them off when they (residents) go to hospital, and it (electronic monitoring safety device) comes back to me. I deactivate them and issue them out if need be." V1 stated, V1 puts the electronic monitoring safety device tag on the activator machine and puts in a code into the machine which activates the electronic monitoring safety device tag showing a blinking red light. V1 stated, "And it lets you test it. You never know, so we always walk by the door with the sensor." V1 stated, V1 trained V5 and V9 on how to activate the electronic monitoring safety devices. V1 stated, extra electronic monitoring safety devices are kept in the social services staff and "each med cart has a few extra ones." When asked how often electronic monitoring safety devices are checked once activated, V1 stated, "Monthly checking and weekly. Nurses check it every day. Social services or I check it weekly." V1 stated, "usually maintenance" does the electronic monitoring safety device alarm system checks.

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When asked if there is a log of the electronic monitoring safety device alarm system checks at the front and basement exit doors, V1 stated, "I took over the whole log. I (V1) check (electronic monitoring safety device alarm systems) at front and back (doors)." When asked how often does V1 perform the electronic monitoring safety device alarm system checks at the front and back basement doors, V1 stated, "Daily when I do my rounds. I cross off for the day (on calendar)," and it's Monday through Friday. When asked the process of how V1 checks the electronic monitoring safety device alarm system at the exit doors, V1 stated, "I (V1) use an (electronic safety monitoring device) that's activated. It's blinking." When asked how close is V1 in front of the exit doors before the electronic monitoring safety device triggers the alarm system, V1 stated, "Probably 6 feet. Alarm is going off. I put the code in. Staff know the code. Or it continues to go off." V1 stated, staff must put the code into the key panel to silence the alarm which reactivates the electronic monitoring safety device alarm system. When asked which exit doors does V1 check for the electronic monitoring safety device alarm system, V1 stated, "The Front and the back (basement)." V1 stated, V22 (Maintenance Supervisor) or V23 (Housekeeping/Maintenance) will do the electronic monitoring safety device alarm system checks on "Saturday or Sunday." V1 then provided this surveyor with a monthly calendar for 2023 for V1's checks of the electronic monitoring safety device alarm system checks. V1 stated, V1 marks the lines through each date which indicates that the electronic monitoring safety device alarm system check was done. When asked if V22 or V23 is doing the checks on "Saturday or Sunday," how is V1 marking that this electronic monitoring safety device alarm system check is being done, V1

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stated, "We (V22 or V23) communicate." When asked if V1 is specifically asking V22 or V23 that the electronic monitoring safety device alarm system was performed, V1 stated, "No, I (V1) ask if everything is okay in general." When asked when was V1 notified of R1 eloping from the facility, V1 stated, "First time, around 12:50 am (9/13/23) by (V2)." V1 stated, V2 informed V1 that V4 informed V2 that R1 was not in facility. V1 stated that a Code Green protocol was called, that the facility and surrounding vicinity was searched, that a police report was filed for a missing person and that hospitals were phoned to see if R1 or a John Doe was in their hospital. When asked how R1 elopee from the facility, V1 stated, V1 checked all of the exits and possible ways that R1 could have left. V1 stated, "I (V1) am still asking are you sure you didn't see (R1)? Is it possible that (R1) was not in this area for a time? (R1) eloped and how (R1) left are big concerns. We have other elopement risk residents and don't want this to happen again." When asked how did R1 walk out unsupervised from the facility on 9/12/23, V1 stated, "I (V1) can't answer that question as to how. I also don't know. It's a question for me. (Electronic monitoring safety device) was working properly. (Electronic monitoring safety device) system was working properly. Did you (staff) hear alarm go off? I wasn't able to see who was going out. That's the question. (R1) got out and (R1's) location is still unaware." When asked what risk does R1 have being in the community without staff supervision, V1 stated, "I (V1) don't have a complete concern that something happened to (R1). Or I don't want to. A more possible concern of how (R1's) eating, where (R1's) sleeping. Homeless concerns. (R1) didn't have family. (R1) not getting (R1's) needs met and meds are more of my concerns. It's my worst nightmare. I am

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S9999	Continued From page 39 really crossing my fingers. It's the same thing every day, (R1's) not found." Facility document titled "Daily (Electronic Monitoring Safety Device) 2023" documents, each month of 2023 in a calendar with blanks lines on the bottom half of the paper. Diagonal lines are marked on every day on the monthly calendar boxes from 1/1/23 to 9/19/23. There is no further documentation noted as to which electronic monitoring safety device exit door is being checked and/or the results of the electronic monitoring safety device exit door checks. On 9/20/23 at 2:11 pm, V2 (Director of Nursing, DON) stated, after social services staff performs a resident's elopement risk upon admission to the facility, a physician order is obtained for the electronic monitoring safety device; social services staff will place the electronic monitoring safety device on the resident; and then nurses will check the electronic monitoring safety device on the resident every shift for the functioning and skin integrity under the electronic monitoring safety device bracelet. V2 stated nurses know that it's functioning when there is a red blinking light on the electronic monitoring safety device. V2 stated, residents with the electronic monitoring safety devices who get close to the front or back basement exit doors will trigger the alarm before the door opens. V2 stated when residents walk out of the side door to the patio, there is an emergency alarm on the patio fence door that when pushed will alarm on the 1st floor for staff to respond. V2 stated, at 3:00 pm, a CNA is posted at the front door to act as security. When asked who is responsible for monitoring the 1st floor nurse's station video camera monitor, V2 stated, it's the 1st floor nurse. V2 stated, the nurse will sign the pass paper for both individual	S9999		

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(independent) or supervised pass levels before a resident can leave the facility to go out on pass to the community. V2 stated, R1 was admitted from the hospital, and V2 welcomed R1 to the facility. V2 stated, R1 spoke Mandarin and English and that R1 would walk around the facility. V2 stated, V2 observed R1 walking on the 1st floor and that R1 was exit seeking. V2 stated, CNAs perform rounds every two hours on all residents and fill out a paper rounds sheet. V2 stated, CNAs must "lay their eyes (on residents) every two hours." V2 stated, residents who are elopement risk residents are to be rounded on "every hour." V2 stated, "On rounds, if the CNA doesn't see the resident, they (CNAs) have to check with reception downstairs. They must go downstairs. They could be outside. They (CNA) must check with social services. Residents can be in activities. CNAs have to physically go on the 1st floor to lay eyes on the resident." When asked how does nursing staff know who the elopement risk residents are, V2 stated, "Elopement risk lists are in all nurse's station. They are aware." When asked when the nursing staff should check the list, V2 stated, "Upon resumption of their shift because there may be a resident that comes in and is added to it. Social Services updates the list." When asked the purpose of why it's important for nurses and CNAs to know who elopement risk residents are, V2 stated, "To properly monitor them and provide safety for them." When asked if R1 was assessed for individual out on pass level, V2 stated, "No." V2 stated nurses must know who the residents are that are out of the facility on an individual or supervised pass by sharing this information in shift-to-shift nursing report. When asked when was V2 made aware of R1 not being in the facility on 9/12/23, "At 11:48 pm from the night shift (V4)." V2 stated, V4 was reaching out via text to

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V2 about a "different thing" and V4 messaged, "FYI (for your information), (R1's) not here." V2 stated, V2 immediately called V4 who informed V2 that R1 was out on pass. V2 stated, "(R1) cannot be out on pass. (R1) cannot be on independent pass." V2 stated, V4 received this information about R1 being out on pass from V3 without specifying which type of pass (supervised or individual) R1 was on. V2 stated, after V2 spoke with V4 over the phone, V2 instructed V4 to call a Code Green and to call 911. V2 stated, V2 then phoned V3 saying, "(R1's) out on pass. That's wrong. (R1) should not be out on pass." V2 stated, V2 asked V3, "when was the last time that (V3) saw (R1), and (V3) said that (V3) didn't see (R1) on 9/12/23 (3:00 pm to 11:00 pm shift)." V2 stated, a Code Green means there's a "missing person not accounted for." V2 stated, nursing staff will conduct a head count of the whole floor to account for residents present to determine who is missing then then can go search the basement and outdoors to the surrounding vicinity. V2 stated, V2 notified V1 after speaking to V4 and that V1 instructed the staff to follow the Code Green protocol, call 911, and collect a missing persons' report. V2 stated, V4 provided the local police department office with R1's photo from R1's Face Sheet and a description of what R1 was known to be wearing last.

Local police department's missing person's report for R1, dated 9/13/23, documents, in part, that R1 was "last seen" on 9/12/23 at 3:00 pm with R1's age group marked as "over 20."

Facility document dated 9/13/23 and titled "Missing Person - Incident Report," V2 (DON) documents, in part, R1's date of incident is 9/13/23 with a "time noted missing: 12:10 am." The actions taken are listed as "Code green

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called immediately. Thorough check of internal and external vicinity of facility. Police notified. Missing persons report filed. (V28, Attending Physician), (V2), (V1) notified. Nearby hospitals contacted." For the line marked "permission to leave facility (M.D. Order)," V2 documented "no." The follow up portion of this incident report when the resident returns is noted blank.

On 9/20/23 at 10:20 am, this surveyor and V22 (Maintenance Supervisor) performed an environmental tour in the facility. V22 stated, the video camera system is "working now," and V24 (Corporate Maintenance Supervisor) fixed the black monitor screen in V1's office. V22 showed this surveyor the video camera monitor screen at the 1st floor nurse's station. This surveyor observed 7 small boxes of camera views noted in the one monitor screen, and V22 identified the following camera views:
Upper left box: Outside patio facing the emergency fence door.
Upper left/middle box: Basement hallway facing conference room.
Upper right middle box: Basement back door facing ramp.
Upper right box: Outside patio view.
Lower left box: Basement hallway facing laundry/kitchen doors.
Lower middle box: 1st floor facing the front door.
Lower right box: Basement hallway by the social services office.

V22 stated, V24 (Corporate Maintenance Supervisor) came and fixed the video camera system after R1's elopement. When asked who is responsible for checking the electronic monitoring safety device alarm systems on the exit doors, V22 stated, "Maintenance." This surveyor and V22 went to the 1st floor front door entrance with

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S9999	Continued From page 43 an activated electronic monitoring safety device (tag). This surveyor viewed the electronic monitoring safety device (tag) with V22. There is a red light blinking on the tag along with a serial number. When asked if this tag has a battery, V22 said, "Yes." When asked what the battery life of the tags is, V22 stated, "I (V22) don't know." When asked how often the facility's electronic monitoring safety device alarm systems on the exit doors are being checked for functioning, V22 stated, "Saturday. Every Saturday." When asked if anyone else checks the electronic monitoring safety device alarm systems on the exit doors, V22 stated, "Only me (V22)." V22 then walked with the electronic monitoring safety device towards the front door, and the electronic monitoring safety device alarm system at the front door began beeping. V22 was approximately 2 feet in front of the front door when the alarm activated (with the door not opening). When asked how far this in distance is before it activated the alarm, and V22 said, "About 1 to 2 feet." When asked if V22 has a log/documentation of V22 performing the weekly Saturday electronic monitoring safety device alarm system checks, V22 said, "Yes." This surveyor and V22 walked down the 1st floor hallway to the patio door (west side of building) leading down an outdoor flight of stairs to the outdoor smoking patio. This patio door on the 1st floor is not locked. V22 stated that there's no electronic monitoring safety device alarm system on this door, and residents walk out to the patio with an electronic monitoring safety device. V22 and this surveyor walked down the outdoor stairs to the smoking patio which has a covered tent with a small open area north of the covered tent. There is a perimeter fence enclosing this outdoor patio area. A camera is mounted on the north side of the building above the emergency exit	S9999		

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S9999	Continued From page 44 door that exists within the north wall of the perimeter fence. This emergency door (wooden fence door) has an emergency bar/locking system, and a sign that reads, "Push until alarm sounds. Door can be opened in 15 seconds." V22 then pushed the emergency bar, and an alarm was beeping outside the facility. V20 stated that it's alarming on the 1st floor nurse's station along with a flashing light. As V22 pushed the emergency bar (surveyor counting to 15 seconds), the patio emergency door opened after 15 seconds. This surveyor and V22 walked back into the facility where on the 1st floor a switch on the wall in nurse's station that turns off the patio emergency door alarm is located. On 9/20/23 at 10:32 am, this surveyor and V22 continued the environmental tour and went to the basement exit door (emergency door) which is the only entrance/exit on the basement level. While walking with the activated electronic monitoring safety device (tag) to test the basement door, V22 walked to the basement door and approximately one foot away from the door, the electronic monitoring safety device alarm system did not alarm/activate. V22 then pushed the emergency exit door bar and walked over the threshold of the door, the electronic monitoring safety device alarm system beeped. V22 walked back into the hallway and put a code into the key panel on the right side of the door to reset the alarm. V22 stated, V22 had to walk through the door to activate the electronic monitoring safety device alarm system. V24 (Corporate Maintenance Supervisor) is near this surveyor and V22 in the hallway in the basement. When asked why the electronic monitoring safety device alarm system is not activating until V22 passes through the door, V24 stated, "No, it should activate about 5 feet before the door." V22	S9999		

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demonstrated again with the electronic monitoring safety device tag walking up to the basement door, and no electronic monitoring safety device alarm system activated until V22 opened the basement door and walked over the threshold of the door to activate the electronic monitoring safety device alarm system.

On 9/20/23 at 10:38 am, V24 (Corporate Maintenance Supervisor) stated, the electronic monitoring safety device alarm system should activate when a resident wearing an electronic monitoring safety device is walking towards the exit door to "advise people that a resident is coming to that area. It'll beep to let staff know." V24 stated, staff will come to check who is by the door or who is going out the door. V24 stated only on the front door on 1st floor and the basement door in back of the building have the electronic monitoring safety device alarm system. When asked who is responsible for testing the electronic monitoring safety device alarm system on the front and back doors, V24 stated, it's V22 who is the maintenance supervisor for this building and V24 has different buildings that V24 is assigned to. When asked how often the electronic monitoring safety device alarm systems on the front and back doors are being tested, V24 stated. "(V22) is supposed to check it every day."

On 9/20/23 at 10:45 am, V22 stated, V22 only checks the electronic monitoring safety device alarm system at the front and back doors "every Saturday." This surveyor walked with V22 to the maintenance office in the basement to view the electronic monitoring safety device alarm system checks log. V21 (Building Engineer) retrieved the binder with the electronic monitoring safety device alarm system checks log. V21 opened the binder, and there are empty electronic monitoring safety

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device alarm system log sheets. V21 stated, V22 is to "make the sheet (log)" when V22 does the electronic monitoring safety device alarm system checks. V21 stated, the electronic monitoring safety device alarm system log sheet was not completed. V21 stated, "That is the problem. I tell (V22), and (V22) did not do it (fill out the log sheet)." V21 stated that V21 taught V22 to do the paper log to show that V22 was performing the electronic monitoring safety device alarm system checks.

Facility document dated 2023 and titled "Electronic Door/ (Electronic Monitoring Safety Device) Log," documents, in part, the electronic monitoring safety device alarm systems for the "front door check" and the "back door check basement." The month is listed at the top of the document, and the time frames for checking the two exits are listed as "Week 1," "Week 2," "Week 3," and "Week 4." This "Electronic Door/ (Electronic Monitoring Safety Device) Log" for September 2023 is completely blank with no documentation.

On 9/20/23 at 10:47 am, V24 stated, V24 was made aware that the video camera was not working and that V24 checked the camera system (after R1's elopement), and it was working, but the picture was not clear. V24 stated, it was one camera monitor that wasn't properly working with the cords running into the monitor, and this was the camera monitor in V1's office (the receptionist and 1st floor nurse's station still properly working). V24 stated, maintenance staff keeps a log for the daily electronic monitoring safety device alarm system checks. This surveyor showed V24 the blank electronic monitoring safety device alarm system checks, and V24 stated, it could be daily or

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weekly because different facilities have different policies. This surveyor informed V24 the facility's policy states daily.

On 9/20/23 at 10:53 am, this surveyor and V22 went up to check V1's office video camera. V22 entered the open door of the office and showed it's the same camera monitor from 9/12/23. V22 stated, V24 fixed it, and "it's working now" with the pictures of the 7 boxes of views of the exits/basement hallways of the facility.

Facility Floor Plan (undated) documents, in part, that there are 3 exit doors to the facility. On the 1st floor, there are two exits: one as the main entrance (north side of the building) and the side exit door leading to the smoking patio (west side of the building). In the basement level, there is one exit door (west side of the building).

On 9/25/23 at 11:05 am, this surveyor requested V1 perform a brief environmental tour for V1 to demonstrate how V1 checks the electronic monitoring safety device alarm system checks at the facility front door and basement door exits. This surveyor asked to see the machine that activates the electronic monitoring safety devices. V1 showed this surveyor the activating machine which looks like a remote control. There is a sign on the activating machine which reads "Low tag battery." When asked if there is a battery in the electronic monitoring safety device tags, and V1 says, "I (V1) guess. I have never seen this." V1 stated, when the tag is blinking red, it's working and V1 uses a tag that has a broken bracelet loop holder on the back piece to do the testing of the front and basement exit doors. When asked if the battery does not work in the tag, does V1 change out the battery, V1 stated, "If the battery goes bad, I (V1) will send it back (to corporate)." V1

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S9999	Continued From page 48 and this surveyor walked to the front entrance door. V1 then walked with the electronic monitoring safety device tag towards the front door, and the alarm began beeping with V1 approximately 3 feet away from the front door. V1 went to the key panel, put in the numeric code, and the alarm stopped with the door being reset. When asked what the purpose of the electronic monitoring safety device system alarm is, V1 stated for residents who have electronic monitoring safety devices on "to prevent them from exiting out the door." When asked about the electronic monitoring safety device alarm system with having a warning alarm prior to the resident exiting the building, V1 stated, V1 doesn't know and that this system was set up prior to V1's employment at the facility. V1 stated, staff putting in the electronic monitoring safety device alarm system "code resets the alarm or it will continue to alarm, and you have to reset it with the code." On 9/25/23 at 11:14 am, V1 and this surveyor continued the brief environmental tour and went down the stairs and walked to the basement exit door. V1 was holding the electronic monitoring safety device tag and walked directly up to the basement door with no alarm going off. V1 pushed open the emergency exit bar walking into the opening door then the electronic monitoring safety device alarm system beeped. V1 put the code in the key panel on the left inside of the door to silence the electronic monitoring safety device alarm, but V1 kept putting in the code without the alarm stopping. V21 came from V21's office in the basement and ask V1, "Do you (V1) still have the sensor in your hand?" V1 told V21 that V1 put the code in the key panel several times, but "it needs a moment to reset." V1 put the electronic monitoring safety device tag on the heater about 6 feet from the door, and V21 put in the code on	S9999		

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the key panel to silence the electronic monitoring safety device alarm system. V1 retrieved the electronic monitoring safety device tag and walked again with the tag towards to the basement door where V1 pushed the emergency bar opening the basement door. The facility emergency door alarm (separate system with key panel on right inside of door) alarmed, but the electronic monitoring safety device alarm system does not activate with light appearing on the key panel of the electronic monitoring safety device alarm system. When asked why the electronic monitoring safety device alarm system did not go off, V1 stated, the electronic monitoring safety device alarm system was not reset. V1 stated, "It has to be reset for the (electronic monitoring safety device alarm system) to work. There are two separate systems. One if for the emergency and the other for (electronic monitoring safety device). I (V1) guess they are linked up, but this was before I came. There are two different sounds for two different systems. V1 stated, V22 (Maintenance Supervisor) checks the electronic monitoring safety device alarm system doors "daily and periodically as well. (V22) usually checks this door with no problem." When questioning V1 about V1 contradicting V1's previous statement on 9/20/23 that V1 does checks the front and back door electronic monitoring safety device alarm system checks on Monday through Friday on V1's rounds, V1 then stated, "(V22) does them since (V22's) close in the basement, and I (V1) do the one (front door exit) upstairs."

On 9/26/23 at 10:18 am, when asked how often V23 (Housekeeping/Maintenance) checks the electronic monitoring safety device alarm systems at the exit doors in the facility, V23 stated, "I (V23) check it when there's a problem. But (V22)

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S9999	Continued From page 50 checks it every weekend." On 9/27/23 at 2:47 pm, V28 (Attending Physician) stated, V28 is the medical director for the facility. When asked if V28 is familiar with R1, V28 stated, V28 doesn't remember the specifics of R1 because V29 (Nurse Practitioner) does rounds on a weekly basis. When asked if V29 reported to V28 about R1/admission, V28 stated, V28 doesn't recollect if V29 did, but that V29 did go out of the country recently. V28 stated that there has been no "action" recently from V29. This surveyor explained to V28 that R1 has diagnoses of schizoaffective disorder bipolar, pain and hypokalemia; that R1 is confused (BIMS 6) and speaks primarily Mandarin Chinese; that R1 has a history of previous elopements; and that R1 eloped via unknown means on 9/12/23 and has not been found yet. When asked if V28 was made aware by facility staff of R1's elopement on 9/12/23, V28 stated, V28 was made aware that R1 had eloped the next day (9/13/23) and that they were on the lookout for R1. When asked about V28's expectations of facility staff in providing supervision for residents to prevent elopements, V28 stated, "They are generally middle aged there. Not older patients. Medical and psych heavy, most of the patients there. I know there's not a lock down unit." V28 stated, nurses must do nursing rounds and "we do make sure they (elopement risk residents) are closer to the nursing station." V28 stated, the staff know who elopement risk residents are by "word of mouth" and that there is a protocol. V28 stated, the "nursing ratio is kind of almost impossible" with the residents who are elopement risk since "the need is distributed" more of nursing for residents with increased medical needs. V28 stated, "Nurses already keep a closer eye." When asked about the electronic monitoring safety	S9999		

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device alarm systems on the exit doors and if the alarm sounds, should staff respond to the alarms, V28 stated, "Yes. Certainly. That's a basic expectation. Regardless of if it's day or night." V28 stated, if a resident "triggers a siren," then the staff should respond immediately. V28 stated, maybe there was a "problem with the (electronic monitoring safety device) plan" for R1 because residents can take the electronic monitoring safety devices off. When asked about the facility's video camera monitoring/footage not being able to rewind to 9/12/23 to even see how R1 left the facility and at what time, V28 stated, "That needs to be looked in to. (V1) can assist you with that."

R1's Census Activity documents, in part, that R1 was admitted to the facility from the hospital on 8/18/23 and was discharged from the facility on 9/19/23.

Facility Assessment (undated) documents, in part, the purpose of the facility assessment is to "demonstrate that (Facility) has reviewed our resident/patient population served, identified their care orders, assessment determined needs and clarified what we do, what we learn, what resources we have to meet needs and care plans," "review direct care staffing needs to meet resident care," and that the findings from the facility assessment assist the facility to "continuously assure that each resident is provided care that allows that person to maintain or attain their highest practicable physical, mental, and psychosocial well-being." The Facility Assessment documents, in part, "Each receives individualized care" with each resident receiving multiple assessments which are used in creation of their care plans. The "Services and Care We (Facility) Offer Based on our Residents' Needs" documents, in part, "The types of care

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S9999	Continued From page 52 that our resident population requires and that we provide for our resident population" includes care for "mental health and behavior" for the care or practices for "care of someone with cognitive impairment" and "care of individuals with other psychiatric diagnoses." The facility's average daily census is documented as 150 residents. Facility policy dated 1/1/2005 and dated "Policy Regarding Missing Residents and Elopements," documents, in part, "Statement Policy: It is the policy of this facility that all residents are afforded adequate supervision to meet each resident's nursing and personal care needs. All residents will be assessed for behaviors or conditions that put them at risk for elopement. All residents so identified will have these issues addressed in their care plans. Environmental Considerations for the Prevention of Missing Persons and Elopements: Residents who are at risk for elopement shall be provided at least one of the following safety precautions by the facility: An (electronic monitoring safety device) and/or, door alarms on facility exits and/or, staff supervision, either by visual contact or video camera. All (electronic monitoring safety device) bracelets will be tested monthly or as needed by the Maintenance department. All (electronic monitoring safety device) exits will be checked daily to ensure proper operation ... Failure to reset and test exit alarms may result in serious employee disciplinary actions ... Staff Training and Education: All staff shall be trained on the proper procedures to follow in the event a resident is found missing from the facility. At a minimum, staff will be trained upon hire during orientation. Missing resident in-service training session shall cover the environmental consideration to prevent elopements, common distraction and redirection techniques, the critical	S9999		

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S9999	Continued From page 53 importance of responding to and investigating the cause of an alarm sounding, missing resident alarm code identification, the chain of command in the event of an elopement ... Procedures for the Prevention of Missing Residents and Elopements: Using the MDS, all residents shall be reviewed for safety concerns and precautions while a resident of the facility. Residents at risk for elopement shall be identified. Residents identified with elopement behaviors that may result in a safety concern, to themselves, shall be documented on the "Residents who Require Supervision or (electronic monitoring safety device) List" form. The "Residents who Require Supervision or (electronic monitoring safety device) List" form shall include the resident name, whether or not they require supervision or an (electronic monitoring safety device). In addition, each resident with an (electronic monitoring safety device) shall have their name on the "Residents with (electronic monitoring safety device)" form and each (electronic monitoring safety device) shall be checked to be in proper working order at a minimum of 3 times weekly which will be noted on this form. At the beginning of each nursing shift or medication pass or at each meal, the charge nurse shall account for all at-risk residents under their respective care. The Procedures for the Residents at Risk for Elopement shall be implemented for any at-risk resident not accounted for. The occurrence shall be documented in the medical record. Unless otherwise identified in the care plan, all residents who are at risk for elopement when leaving the facility property shall be accompanied. The accompanying party shall sign the resident out of the facility on a resident sign-out sheet. Should an alarm on one of the external exits to the facility be sounded, staff shall immediately respond to determine the cause of the alarm. After the	S9999		

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facility's staff investigates an exit alarm, and no reason can be found for the sounding of that alarm, they shall announce a specific resident code alert over the facility's public address system (i. e. (that is) Code Green). Upon the announcement of the missing resident alert code, the Director of Nursing or designee using the daily census sheet will coordinate a complete head count of all residents. If, after all residents are accounted for, the cause of the alarm is still undetermined, the Director of Nursing or designee shall continue a reasonable investigation to determine the cause of the alarm ... Procedures for the Response of Missing Residents and/or Elopements: In the event a resident is discovered missing, the following procedures shall be strictly followed: The administrator or designee of the facility shall coordinate an investigation in which both the inside and outside of the facility are thoroughly searched. Particular attention shall be paid to identify hazards both inside and outside the building. Should a search of the inside and outside of the building prove unsuccessful, the immediate vicinity surrounding the facility shall be searched and all potential witnesses questioned regarding the whereabouts of the residents."

Facility policy dated 3/24/2021 and titled "Outside Pass Policy," documents, in part, "Introduction and Background: This nursing facility emphasizes and expects respectful, mature conduct from each resident both within the facility and when out in the community. Because of a combination of mental health, physical problems, and/or a history of substance abuse and irresponsible, dangerous behavior, it is recognized that most residents are not capable of navigating safely in the community. Residents may not be considered for community outside pass privileges without a physician's

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S9999	Continued From page 55 order. Procedure: 1. Newly admitted residents will be evaluated over the first seven (7) days of their stay to determine: Cognitive status (including judgement, rational thinking, insight, and sensible decision making). Ability to engage in safety and harm reduction practices. Degree and severity of mental and/or physical illness. Addiction history and present addictive behaviors (including susceptibility to engage in high-risk behavior). Community safety skills including engaging in appropriate and acceptable social behavior ... 2. In order to maintain resident safety, each resident will be screened to determine their pass level upon admission, readmission, annually, and as needed (as determined at the discretion of the IDT (intradisciplinary team), Administrator, or physician). Residents who present as aox0-2 (alert, oriented times two (person, place, or time)) will be given a Supervised Pass without further assessment ... 3. Decisions regarding pass privileges, including, independent or being accompanied by a responsible individual are at the discretion of the attending physician, social services director and administration ... The Physician's Order Sheet (POS) shall reflect the physician's order prior to the resident receiving pass privileges ... 7. Family members or other interested (responsible) parties who wish to escort a resident on an outside pass are responsible for: (A) Participating in an educational session or sessions with the nursing staff so they may better understand the resident's pressing medical needs (including, but not limited to, taking necessary medication in prescribed treatments), (B), Properly sharing detailed information about planned events and their location/phone number and return to facility and (C) Properly notifying the resident's nurse and signing out prior to leaving the unit."	S9999		

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Facility job description dated January 2008 and titled "Nurse (RN, LPN)" documents, in part, "Purpose of the Position: The primary purpose of the position is to provide direct nursing care to the residents, and to supervise the day-to-day nursing activities performed by nursing assistants. Such supervision must be in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be required by the Director of Nursing or Charge Nurse to ensure that the highest degree of quality care is maintained at all times. Duties and Responsibilities: Administrative Functions: 1. Supervise & direct the day-to-day functions of the nursing assistants in accordance with current rules, regulations, and guidelines that govern the long-term care facility. 2. Ensure that all written policies and procedures that govern the day-to-day functions of the nursing service department are followed ... 4. Cooperate with other IDT (intradisciplinary team) personnel when coordinating nursing services to ensure that the resident's total regimen of care is maintained. 5. Ensure that all nursing service personnel are following their respective job descriptions. 6. Perform administrative duties such as completing medical forms, reports, evaluations, charting, etc., As necessary ... 8. Make written and oral reports\recommendations concerning the activities of your shift as required. 9. Me with your assigned that CNA's, as well as IDT members, in planning the shifts services, programs, and activities ... 11. Complete accident or incident reports as necessary. 12. Maintain the Daily Census Report and submit to Administration as required ... 16. Make daily rounds of your unit to ensure that nursing service personnel are performing their work assignments in accordance with acceptable nursing standards

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S9999	Continued From page 57 ... 18. Provides supervision and leadership to nursing personnel assigned to your unit or shift. Charting and Documentation: 1. Fill out and complete accident or incident reports. Submit to Director as required. 2. Chart all accidents or incidents involving the resident. Follow established procedures ... Resident Care Functions: ... 3. Ensure that your nurses' notes reflect that the care plan is being followed. 3. Review resident care plans for appropriate resident goals, problems, approaches, and revisions based on nursing needs." Facility job description dated January 2009 and titled "Certified Nursing Assistant," documents, in part, "Purpose of the Position: The primary purpose of the position is to provide your assigned residents with routine daily nursing care in accordance with our established nursing care procedures, and as may be directed by your supervisors. Duties and Responsibilities: Administrative Functions: ... 2. Report all accidents and incidents you observe on the shift that they occur ... Personnel Functions: ... 2. Perform all assigned tasks in accordance with our established policies and procedures, and as instructed by your supervisors ... Nursing Care Functions: 1. Participate in and receive the nursing report upon reporting for duty. Complete rounds ... Safety and Sanitation: 1. Notify the Staff Nurse of any resident leaving or missing from the facility." Facility job description dated January 2005 and titled "Administrator," documents, in part, "Purpose of the Position: The primary purpose of the position is to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern long-term care facilities to	S9999		

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assure that the highest degree of quality care can be provided to our residents at all times. Delegation of Authority: As the Administrator, you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties. Duties and Responsibilities: 1. Plan, develop, organize, implement, evaluate, and direct the facility's programs and activities ... Safety and Sanitation: 1. Assure that all facility personnel, residents ... follow established safety regulations ... 7. Assure that the facility is maintained in a clean and safe manner for resident comfort ... Miscellaneous: ... 2. Assure that each resident receives the necessary nursing, medical and psychosocial services to attain and maintain the highest possible mental and physical functional status, as defined by the comprehensive assessment and care plan."

Facility job description dated January 2005 and titled "Director of Environmental Services," documents, in part, "Purpose of the Position: The primary purpose of the position is to plan, organize, develop, and direct the overall operation of the Housekeeping, Laundry and Maintenance Departments in accordance with the current federal, state and local standards, guidelines, and regulations governing our facility, and as may be directed by the Administrator, to assure that our facility is maintained in a clean, safe, and comfortable manner. Duties and Responsibilities: Administrative Functions: 1. Plan, develop, organize, implement, evaluate, and direct the Housekeeping, Laundry and Maintenance Departments, its programs and activities ... 7. Perform administrative duties such as completing necessary forms, reports ... Environmental Service Functions: 1. Assure and that the facility is maintained in a clean and safe

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manner for resident comfort and convenience by assuring that necessary equipment and supplies are maintained and operable to perform necessary duties and services ... 16. Maintain and repair if needed the proper function of all facility equipment."

Facility job description dated January 2008 and titled "Receptionist," documents, in part, "The primary purpose of this position is to perform clerical duties, record keeping, maintaining the upkeep of office, assisting in the supervision of the residents to insure (ensure) that the facility meets the highest standards for each resident, and to give them the proper care and quality of our service. Receptionist Functions: ... 2. Monitor the front door to screen and residents at risk for elopement before they leave the facility ... 12. Make sure that all office functions are maintained ... Check (electronic monitoring safety devices) of selected residents, make sure the residents are not loitering in the front foyer and/or the front porch ... 14. Check alarms and respond accordingly."

Facility job description dated January 2005 and titled "Administrative Assistant" (BOM), documents, in part, " ... Administrative Functions: ... 6. Monitor the front door to screen and residents at risk for elopement before they leave the facility."

On 9/25/23 at 11:40 am, V1 confirmed that the census of the facility on 9/19/23 when this surveyor entered the facility was 143 active residents.

Facility manual for the (Electronic Monitoring Safety Device) System, LC 1200, dated January 2012, documents, in part, that the "function of the

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S9999	Continued From page 60 (Electronic Monitoring Safety Device) System, LC 1200, is to alert facility personnel of the possible egress of a monitored resident and can be utilized for special care residents suffering from wandering malady or tendencies of straying into unauthorized areas or leaving a facility." For addressing alarms of the (Electronic Monitoring Safety Device) System, LC 1200, this manual documents, in part, that staff are to go to the door that is alarming and if the red light is illuminated on the keypad, immediately search for tagged residents with the following notes: "It is especially important to open the door to verify that no resident has wandered out beyond the monitored area. Keep in mind that even if there are tagged residents near the door, but inside the monitored area, it is still imperative that you check outside and don't assume that everyone is accounted for. If a resident is found outside, escort them back inside and reset the zone by entering a keypad code. If no residents appear to have gone out beyond the monitored area, then check the area near the door inside of the monitored area for tagged residents. Escort any tagged residents lingering near the area out of the area close to the door and reset the keypad." (A)	S9999		