STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006266	A. BUILDING: _____ B. WING _____	08/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONMOUTH NURSING HOME	117 SOUTH I STREET MONMOUTH, IL 61462

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S 000	Initial Comments Complaint Investigation #2226604/IL150324 Facility Reported Incident of 8/17/22/IL150315	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.690a) 300.1210b) 300.1210c) 300.1210d)6) 300.3240a) 300.3240b) 300.3240c) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect	S9999		

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S9999	Continued From page 2 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative and to the Department. (Section 3-610(a) of the Act) These Requirements were not met evidenced by: Based on observation, interview, and record review, the facility failed to ensure a door monitoring system for cognitively impaired residents that are assessed as high risk for leaving the facility unattended, was in proper working order; failed to perform recommended weekly door alarm function tests; failed to ensure staff did not engage in the unauthorized practice of propping open exit doors bypassing the door monitoring system; failed to respond timely to door monitoring system alarms; failed to ensure a cognitively impaired, wandering resident's electronic monitoring bracelet was in working order to prevent an elopement; failed to monitor the proper function and placement of resident's electronic monitoring bracelet, every shift; and failed to recognize an incident of elopement as an elopement for three of three residents (R4, R5 and R6) reviewed for elopement, in a sample of three.	S9999		

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S9999	Continued From page 3 Findings include: The facility policy, Elopements, (revised) December 2007 directs staff, "It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible. All residents will be assessed for behaviors or conditions that put them at risk for elopement. For the purpose of this policy, "missing resident" shall be defined to mean a resident who has left the facility grounds without signing him/herself out of the facility. The resident shall not be designated as "missing" or "eloped" if he/she is seen leaving the buildings or is seen walking away as a result of responding to a door alarm. Residents who are at risk for elopement shall be provided at least one of the following safety precautions by the facility: Door alarms on facility exits; A personal safety device that will alert facility staff when the resident has left the building without supervision (Code Alert or [electronic monitoring] bracelet/ankle system) and/or Staff supervision. As part of the facility's Preventative Maintenance Program, all door alarms will be checked for proper function on a weekly basis. At no time shall a personal safety alarm (electronic monitoring bracelet) or door alarm be turned off without the continual supervision of the exit. The person responsible for turning off the personal safety alarm or door alarm shall be responsible for resetting the alarm and ensuring that it is in working condition. Failure to reset and test exit alarms will result in serious employee disciplinary action, which can include immediate termination. When a door alarm sounds, staff shall immediately respond to and determine if a resident has exited the building. If, upon investigation, no reason can be found for the sounding of that alarm, the Charge Nurse shall initiate an accounting of all residents	S9999		

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S9999	Continued From page 4 at risk for elopement. If, after all at-risk residents are accounted for, the cause of the alarm is still undetermined, a complete head count of all residents will be conducted. All staff shall be trained on the proper procedures to follow in the event a resident is missing from the facility. At a minimum, training and in-service education shall be conducted for each staff member upon orientation and annually, thereafter." The facility (Personal Elopement Safety Bracelet System/electronic monitoring bracelet) User and Instillation Manual 16900 Series directs the user, "Read and follow these instructions carefully before using your system. Failure to do so could cause an unauthorized departure resulting in injury or death. Warning: "Personal Elopement Safety Bracelet System" equipment must be operated by trained personnel only who are thoroughly familiar with the procedures outlined in this User Manual. Test the System regularly. Test each monitoring system weekly with all surrounding power devices turned on. Record the results. Test bracelets daily as detailed in the bracelet instructions and the Tester Manual. Record the results in each resident's records. A staff member must be within hearing distance of the alarm or a remote nurse station annunciator at all times. Inspect the System door antennas and magnetic switches at least weekly to be certain that all wire connections are secure. Make daily inspections to confirm the wristband is in place (on the dominate wrist) on each resident and is not damaged in any way. The (Personal Elopement Safety Bracelet System/electronic monitoring bracelet) is an electronic monitoring system designed to assist staff in facilities that care for people who may present wandering risks. If a resident wearing an (electronic monitoring bracelet) attempts to pass through a monitored	S9999		

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S9999	Continued From page 5 area, an alarm sounds to alert staff to a possible departure. The alarm continues to sound until staff silences the alarm. Remote Annunciator: the remote annunciator gives a warning before a wandering resident goes out the door. Used at (the) nurse's station, the light panel on the remote annunciator displays a "condition yellow" and emits a discreet beep when a monitored resident is within range of a System door monitor. This helps promote a quicker response from staff if an unauthorized exit does occur, and in many cases the resident can be simply escorted away from the door, avoiding a departure altogether." 1.) R4's facility Admission Record form documents that R4 was admitted to the facility on 8/28/20 with the following diagnoses: Dementia, Chronic Obstructive Pulmonary Disease, Repeated Falls. R4's current (8/18/22) facility Elopement Risk Assessment documents, "(R4) is cognitively impaired and independently mobile, has a history of elopement, a desire to leave the facility and exit seeks with a purpose." This same assessment documents, "(R4) appears to be a visitor and has a diagnosis of dementia. The following interventions are in place: application of an electronic monitoring bracelet/device, (R4's) picture in the (facility) elopement book and (requires) frequent visual monitoring." R4's current Minimum Data Set Assessment, dated 5/11/22 documents, "Section C: Cognitive Patterns 8:15 (moderately confused) and Section G: Functional Status: Requires the use of a walker." R4's current Care Plan, dated 8/28/20 includes the following Focus area: (R4) is an elopement	S9999		

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S9999	Continued From page 6	S9999		

risk/wanderer as evidenced by (R4) is often confused and thinks she needs to go home, (R4) has opened (exit) doors recently. Also included are the following Interventions: Make sure (R4) has her wheeled walker when ambulating; Monitor closely when in hallways; Monitor for placement of (electronic monitoring bracelet) and ensure it is working properly every shift. Respond promptly to alarms.

R4's Nursing Progress Notes, dated 12/18/21 at 3:30 PM and signed by V6/Registered Nurse (RN) document, "(R4) exited through the side (Exit) door. Stopped by this nurse. Said she was going to the bank. Redirected her as to where she was and the colder temperatures out (side) at current time. (R4) came back into the building without any complications. Will continue to monitor."

R4's Nursing Progress Notes, dated 2/24/22 at 11:35 AM, and signed by V5/Licensed Practical Nurse (LPN) document, "(R4) opened the side (Exit) door leading to laundry. (R4) stepped outside and was redirected back into the building by a housekeeper. (R4) had her coat on and stated she was going home. (R4) then stated she wanted to talk to Social Services."

R4's Nursing Progress Notes, dated 2/24/22 at 2:08 PM document, "Personal (electronic monitoring bracelet) put on (R4's) right ankle."

R4's Nursing Progress Notes, dated 8/17/22 at 4:45 PM and signed by V2/Director of Nurses document, "At approximately 4:45 PM on 8/17/2022 assigned nurse (V2) for (R4) noticed (R4) was not in her room. At approximately 5:15 PM, facility was notified by (R4's son) that (R4) was at her sister's house, approximately three

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S9999	Continued From page 7 blocks from facility. Son accompanied (R4) back to the facility at approximately 6:00 PM" The facility Investigation Report, dated 8/17/22 and signed by V1/Interim Administrator documents, "At approximately 4:45 PM, assigned nurse for (R4) noticed she was not in her room. At approximately 5:15 PM the facility was notified by (R4's) son that (R4) was at her sister's house, approximately three blocks from the facility. Son accompanied (R4) back to the facility at approximately 6:00 PM Summary of Critical Information Obtained During Investigation: During search of interior of facility it was determined that an exterior door in the kitchen was open and a (Unalarmed) screen door closed, to (give) access to the exterior of the property. Dietary staff members (R15/Dietary Aide and R26/Dietary Aide) state they opened the door due to excess heat in the kitchen. Immediate Action Taken During Investigation: (V1/Interim Administrator) checked all doors for (Alarm Elopement System) function. (An) issue was identified with the (Alarm Elopement System) panel at nurse's station, for door 7. (V1) to call the Company on 8/18/22." On 8/19/22 at 2:00 PM, R4 was observed ambulating with a front wheeled walker in the hallway, near the SE (Southeast) door (Door 7). No facility staff were present. An electronic monitoring bracelet was present to R4's left ankle. On 8/19/22 at 2:10 PM, V1/Administrator stated, "I don't have any investigations of (R4's) prior elopement attempts. I wasn't the (facility) administrator at the time. (V2/DON) is unable to recall if they were ever investigated or what new interventions were put in place to prevent further attempts."	S9999		

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S9999	Continued From page 8 2.) R5's facility Admission Record documents that R5 was admitted to the facility on 3/18/19 with the following diagnoses: Alzheimer's Disease and Hallucinations. R5's current facility Elopement Assessment, dated 8/17/22 documents, "(R5) is cognitively impaired and independently mobile with a history of elopement and a diagnosis of Alzheimer's Disease. (R5) is an elopement risk/wanderer and has a wander alert bracelet/(electronic monitoring bracelet) in place." R5's current Minimum Data Set Assessment, dated 5/11/22 documents, "Section C: Cognitive Patterns 4:15 (cognitively impaired) and Section G: Functional Status: Requires the use of a walker." R5's current Care Plan, dated 10/21/2020 includes the following Focus areas: (R5) is an elopement risk/wanderer. 8/16/22 (R5) had Exit attempt on 8/3/22, stated he was going home. IDT (Inter Disciplinary Team) placed wander alert bracelet/ (electronic monitoring bracelet) on (R5) due to previous exit attempts. R5's current Treatment Administration Record, dated August 2022 includes the following physician order: Check (electronic monitoring bracelet) on left wrist every shift. Staff initials documenting completion of this order are only present at 6:00 AM, 2:00 PM and at 10:00 PM on 8/8/22. R5's Nursing Progress Notes, dated 8/3/22 and signed by V2/Director of Nurses (DON) document, "(R5) exited the front door, stating he was trying to go home."	S9999		

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S9999	Continued From page 9 R5's Nursing Progress Notes, dated 8/7/22 at 11:57 PM document, "(electronic monitoring bracelet) applied to left wrist." On 8/19/22 at 1:55 PM, R5 was seated in a chair across form the nurse's station. An electronic monitoring bracelet was present to R5's left wrist. On 8/19/22 at 2:15 PM, V2/Director of Nurses stated, "We didn't do an investigation when (R5) left the building (August 3, 2022). We didn't have a(n) (electronic monitoring bracelet) to put on him (August 3, 2022). We only have three of them. We haven't been able to order anymore because our bill hasn't been paid. When another resident left on the eighth (August 8, 2022) we put a(n) (electronic monitoring bracelet) on (R5). Nurses are supposed to visualize the bracelet and check the function of the bracelet, each shift and document the results. I don't know why they weren't doing that (for R5)." 3.) R6's admitting diagnoses: Intracranial injury with loss of consciousness of the sequela, and Dementia with behavioral disturbance. R6's Admission Elopement Assessment, updated (8/18/2022), and signed by V25/Social Worker documents Elopement Risk: (R6) is cognitively impaired and independently mobile, Elopement Risk Factors: (R6) has a diagnosis of Alzheimer's Dementia, and is at risk for elopement. History of Elopement: (R6) has a history of elopement and wondering activity. Interventions that are put in place to prevent (R6) from eloping: 1.) Application of monitoring bracelet, 2.) Picture in elopement book, 3.) Frequent visual monitoring. Elopement needs: (R6) is an elopement risk/ wonderer, has a history of trying to exit the building. (R6)	S9999		

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S9999	Continued From page 10 wanders the hallways and goes in and out of other resident's room. (R6) does not always know where (R6) room is. (R6) now has a roam alert bracelet/(electronic monitoring bracelet) related to exit seeking. Exit attempt on 8/13/2022. (R6's) Admission Care Plan, dated 2/3/2021, includes a care plan for (R6) elopement. (R6) is an elopement risk/wanderer, has a history of trying to exit the building. (R6) wanders in the hallway and into other residents rooms, and lays in the beds. (R6) intervention: (R6) roam alert bracelet/(electronic monitoring bracelet) is on, and must be monitored every shift for proper placement and functioning. (R6's) Minimum Data Set Assessment, dated 8/5/2022, documents under Section AC: Cognitive Patterns-BIMS (Brief interview for Mental Status) is a (99) (R) is unable to complete interview.) The same form documents under Section G: Cognitive Skills for Decision Making is a (3) Severely Impaired-never/rarely made decisions. The same form Section G under Functional Status: Balance During Transition and Walking documents (R6) is not steady, but able to stabilize without staff assistance. (R6's) Progress Notes, dated 7/31/2021 at 1:46 PM documents, (R6) got out of laundry door and started down the ramp. Staff approached (R6) and assisted (R6) back into building with some resistance. (R6) returned to (R6) room. (R6) Progress Notes, dated 8/7/2022 at 1:31 AM documents, (R6) roam alert bracelet/(electronic monitoring bracelet) does not register. (R6) Progress Notes, dated 8/13/2022 at 1:57 PM documents, V16/CNA (Certified Nursing	S9999		

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S9999	Continued From page 11 Assistant) approached nurse while on lunch break and stated, that (R6) had gotten out of the back door of the building and was in the facility parking lot. V23/Housekeeper had been in the laundry room and saw (R6) attempting to walk into the street when V23 alerted V16. With help of V16 and V23 they were able to get (R6) back into the building and get (R6) laid down in bed. (R6) roam alert bracelet/(electronic monitoring bracelet) was tested and found to be disabled and that was how (R6) was able to get out without alerting staff. A new roam alert bracelet/ (electronic monitoring bracelet) was tested and placed on (R6) and is in full working capacity. (R6) Progress notes, dated 8/19/2022 at 3:49 PM documents, Noted this morning that (R6's) roam alert bracelet/(electronic monitoring bracelet) was not functioning and therefore (R6) will be put on a one on one and a 15 minute check. On 8/22/2022 at 10:24 AM V24/LPN (Licensed Practical Nurse) stated, "Last Saturday I was on lunch break and V16/CNA (Certified Nursing Assistance) came outside to inform me that (R6) was found outside near the dumpster. (R6) became combative, so V23/Housekeeper left (R6) outside to come and get help. V16/CNA and V23 were able to get (R6) back into the building and V24/LPN checked (R6) alarm and found it to be nonfunctional, another band was found for roam alert bracelet/(electronic monitoring bracelet) and replaced it for the nonfunctional band." On 8/22/2022 at 9:43 AM V23/Housekeeper stated, "V23 was outside in the shed doing laundry and I could see (R6) outside the door roaming around, (R6) was near the ramp by sidewalk. V23 tried to get (R6) inside, but (R6)	S9999		

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became combative. So, I left (R6) outside and ran inside screaming for someone to help me. V16/CNA (Certified Nursing Assistant) helped to bring (R6) back into the building."

On 8/22/2022 at 11:46 AM V16/CNA stated, "V23/Housekeeper was running through the hallways screaming for help. V23 said (R6) was outside and (R6) became combative and V23 wasn't able to get (R6) back into the building. V16 went outside to get (R6) and (R6) was standing by the wheelchair ramp, V16 was able to get (R6) inside the building with no problem. (R6's) roam alarm bracelet/(electronic monitoring bracelet) was not working properly, and did not go off as it should when going in and out of the doors."

On 8/18/20222 at 11 AM (R6) was up walking up and down the hallways appeared to be confused. (R6's) electronic monitoring bracelet was on (R6's) left ankle.

On 8/19/2022 at 3 PM (R6) was sitting at the nurses' station playing a board game with a staff member sitting next to (R6), the electronic monitoring bracelet location had been changed and was now in place on (R6's) right wrist area.

On 8/19/22 at 8:45 AM an In-Service Education/Meeting Form was hanging at the Nurse's station desk. This form documented, "RE: Doors. No doors should be propped open at any time due to safety and elopement risk. All staff must sign below." This form documented V2/Director of Nurses as the Instructor. At that time, V6/Registered Nurse stated, "Some of the night shift staff have been placing a piece of paper in the doorframe to by-pass the alarm, when they go outside and smoke. Everybody knows about it. Evidently they finally got caught."

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S9999	Continued From page 13 The facility form, (Alarm Alert System) Door Module Testing Calendar 2022, provided by V10/Maintenance Director on 8/22/22, documents, "Door Module Testing. Door modules must be tested at least weekly on each shift, with all other surrounding power devices turned on. Record the testing results by initialing the appropriate date. Failure to do so could result in injury or death to a person in your care." No documentation of the dates and shifts for the required weekly testing on the Personal Alarm Safety System were noted. On 8/19/22 at 8:49 AM, V2/Director of Nurses (DON) confirmed the In-Service/Education Meeting form, dated 8/8/22 was to educate staff concerning the propping of doors when exiting the building to smoke and due to kitchen staff propping the Exit door in the kitchen, open. V2/DON also stated, "I was the nurse working on August seventeenth, second shift, when (R4) eloped from the building. I don't recall when I saw her earlier in the shift, but around 4:45 (PM) I went to give her medications and (R4) wasn't in her room. Her sister was in the room and said she didn't know where she was. I checked the dining room and up by the nurses' station. I called (V3/Assistant Director of Nurses) and (V5/Licensed Practical Nurse) to see if (R4's) family had signed her out earlier in the day and they both told me no. I finally called her son and he said he didn't know where she was, and he would start looking for her. Around 5:15 (PM), (R4's) son called back and said his Aunt had called him and said (R4) had walked to her house. (R4's) son brought (R4) back to the facility around 6:00 (PM), (V17) and V18/Certified Nursing Assistants) CNAs came on duty at 2:00 PM that afternoon. When I asked them if they	S9999		

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heard an alarm, they said no. The last person we can figure out that saw (R4) was (V22/Activity Assistant). She remembers handing (R4) a root beer float sometime around 3:30 PM She wasn't really sure of the time. I didn't hear any alarms go off. I don't know which door she went out of or if someone reset the alarm. We have been having problems with Door 7 (Southeast) door. Something is broken and it doesn't always alarm at the nurses' station."

On 8/19/22 at 9:18 AM, V1/Administrator stated, "I was alerted by (V2/Director of Nurses) on Wednesday night, around 4:45 (PM), that they couldn't find (R4). I did a head count (of residents), searched the building, and searched the perimeter of the building. We alerted (R4's) son and he called back around 5:15 (PM) to say his aunt had called him and said (R4) had somehow walked to her house. R4 is a fall risk but walked all the way without a walker. (R4's) sister had just moved into this house and (R4) had never been there before. The son brought (R4) back around 6:00 PM. When I checked all the (Exit) doors in the building, I found the kitchen staff had propped open the kitchen screen door and found that door 7 (Southeast) door alarmed at the door, but it didn't sound at the nurses' station panel. It's broken. I have alerted the (Elopement Alarm) company and they are supposed to be coming out on Monday (8/22/22). (V10)/Maintenance man is supposed to be checking the doors weekly, but I don't think he has been doing it. When I called the (Elopement Alarm) company to see when they had come to look at the alarm system, they told me it was a couple of years ago. Evidently our company has an unpaid bill and the (Elopement Alarm) company won't come out and fix door 7 until they get paid. I have notified the company and they

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S9999	Continued From page 15 are working on getting a check cut. All staff are responsible for answering alarms at the doors, but I have to tell you, the (elopement alarms) are very faint. You can't hardly hear them. I know that the staff is very slow to respond to alarms and until I came about a month ago, they didn't even have a protocol to follow when an alarm went off." On 8/19/22 at 10:14 AM, V12 (R4's sister) stated, "(R4) just showed up at my door (Wednesday, August 17, 2022) around 3:00 (PM) or so. (R4) was sweating real bad and was breathing hard. We sat in the air conditioner and drank a (soda) and (R4) rested. (R4) didn't have her walker with her. (R4) said at the time that it felt like it was one hundred degrees outside. I called (V13) (R4's son) and told him that somehow (R4) had shown up at my door. (R4) had never been to my house before, I just moved here. (My house) is about six or seven blocks from the home (facility). Good thing (R4) didn't turn the other way, she would have ended up on the highway." On 8/19/22 at 10:26 AM, V13 (R4's son) stated, "I was having a late lunch with my nephew (Wednesday, August 17, 2022) around 4:30 (PM) when the home (facility) called and asked if I knew where mom (R4) was. I was upset. They (facility) should know where my mom (R4) is at all times. I told them that she (R4) wasn't with me, but I would start searching for her (R4). Around 5:15 (PM) or so, my aunt (V12) called and said my mom (R4) had showed up on her front porch, without her walker and out of breath. My aunt (V12) sat mom (R4) down in the air conditioning and gave her something to drink. I drove over to my aunt's house, and she (R4) was still hot and sweaty. We sat there for a while, while she (R4) caught her breath and then I drove her (R4) back to the home (facility) around 6:00 (PM). It's ten or	S9999		

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eleven blocks from the home (facility) to my aunt's house, with no sidewalks. That means she (R4) had to walk in the roads. She (R4) is lucky she (R4) didn't get hit by a car. Or fall, she (R4) didn't even have her walker with her, and she (R4) has fallen at the nursing home (facility) a number of times already. I know she (R4) has an alarm bracelet on. I'm aggravated, they (facility) didn't even call the police. I'm the one that had to go looking for her (R4)."

On 8/19/22 at 10:57 AM, V6/Registered Nurse stated, "(R5, R6 and R4) all have alarm bracelets on but, (R6's) bracelet doesn't work. It's inactive. The nurse is supposed to use the tester and check each alarm bracelet, every shift and document it on the TAR (Treatment Administration Record). We didn't really have a protocol (when someone went out the door) until recently. It's also really hard to hear the alarms and door 7 doesn't work, so when you are at the nurses' station, you can't hear the alarm."

On 8/19/22 at 12:24 PM, V14/Certified Nursing Assistant (CNA) stated, "Third shift has a bad habit of putting a piece of paper in the doors. It allows them to go outside and smoke and the alarm on the door is bypassed."

On 8/19/22 at 12:26 PM, V8/Certified Nursing Assistant stated, "Door 7 (Southeast) door hasn't worked for a long time. I know some of the girls go out that door to get to their cars and smoke. I don't know when the last training on the door alarms was. Up until recently, we didn't really have a protocol to follow when a resident with an alarm bracelet went out the doors."

On 8/19/22 at 12:34 PM, a tour of the facility kitchen showed an Exit door to the North side of

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the building. At that time, the interior door was open, and a screen door was open, to the outside. V15/Cook verified the open door and stated, "We open this door, because it gets so hot back here." V15/Cook also verified she was working the afternoon that (R4) left the facility unnoticed and unattended and the screen door was also open at that time.

On 8/19/22 at 2:49 PM, V11/Elopement Alert Company Representative stated, "The last service date on the alarm system was 2020. We recommend servicing of the system yearly. The last time the facility ordered elopement alert bracelets/(electronic monitoring bracelets) was 2015."

On 8/22/22 at 10:51 AM, V17/Certified Nursing Assistant stated, "I was working the afternoon that (R4) left the building. I was answering call lights and taking people (residents) to the bathroom. (V2/DON) came around and asked if I had seen (R4). I told (V2) I hadn't seen (R4). I started searching the building, then got in my car and started driving around. Someone eventually texted me and said that they had found (R4). (R4's) wander alert/(electronic monitoring bracelet) did not go off. I didn't hear any alarms. (R4's) walker was in her room. I don't remember the last time I had training on the alarms."

On 8/22/22 at 11:00 AM, V10/Maintenance Director stated, "I have been the Maintenance Director for just a few weeks. I had about a week that I worked with the previous Maintenance Director. He retired. I didn't get much trailing on the (door) alarms. I know that Door 7 has been broken for a while."

On 8/22/22 at 11:30 AM, V20/Certified Nursing

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S9999	Continued From page 18 Assistant stated, "I work third shift. I know some of the girls have been propping the doors open (by-passing alarms) when they go outside to smoke. I don't remember the last training we have had on the alarms." On 8/22/22 at 12:40 PM, V21/Elopement Alarm Company Representative stated, "Door 7 is broken. I don't have the part with me to fix it. We hope to get it installed tomorrow morning." On 8/22/22 at 12:50 PM, V22/Activity Assistant stated, "We don't have an Activity Director. I'm the only part time Activity Assistant. I have been here one month. I was a truck driver previously. I don't know much about the door alarms or the elopement alarm bracelets/(electronic monitoring bracelets). I was working the afternoon when (R4) left the building. I started passing root beer floats around 2:30 (PM). (R4) would have been about my sixth resident. (R4) was in her room. (R4) didn't appear agitated or anything. (R4) was looking forward to the root beer float. When I left, (R4) was sitting in her chair, eating her float. I didn't hear any door alarms after that." On 8/23/22 at 2:30 PM, V27/Certified Nursing Assistant (CNA) stated, "I was the second CNA working when (R4) eloped. We only have 2 (CNAs) on second shift. I was answering call lights. I hadn't seen (R4) yet that afternoon. I don't recall hearing any alarms, to let us know (R4) had left the building. Once we found out that (R4) left the building, I stayed in the building and (V17/CNA) left in her car to look for (R4)." (A)	S9999		