STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015895	A. BUILDING: _____ B. WING _____	C 10/29/2024

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S 000	Initial Comments Complaint Investigations: 2448472/IL179494 2448515/IL179546	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	S9999		

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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

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to provide supervision/monitoring to prevent an elopement for 1 of 11 residents (R2) reviewed for supervision to prevent elopement in the sample of 11. This failure resulted in R2, eloping from the facility on 10/15/24 sometime between 3:00 PM to 4:00 PM. R2 was found by a passerby at approximately 4:30 PM, was assessed at the local hospital and returned to the facility.

Findings include:

R2's Admission Assessment, dated 10/4/2024 at 9:45 AM, documents R2 was admitted from home. She was assessed to have clear speech and was orientated to person only, confused and agitated. Elopement Risk Assessment documents supervision with walk in room and locomotion on and off unit, decisions regarding tasks of daily life: moderately impaired. Behaviors: anger facility placement and verbalizing statements about leaving. Resident experienced new admission.

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S9999	Continued From page 2 Contributing diagnoses: Alzheimer's disease, dementia other than Alzheimer's disease, dementia other than Alzheimer's disease. Resident assessed as an elopement risk. R2's Late Entry Nurse Progress Note, dated 10/4/2024 at 10:31 AM, documents "(R2) was admitted on 10/4/2024 at 9:45 AM... from home. (R2) is unaware that family wants this to be a long-term placement as she is unsafe at home due to her progressing dementia. (R2) is confused and thinks she is at the hospital and will go home as soon as the doctor evaluates her. Resident is alert to self." R2's Nurse Progress Note, dated 10/5/2024 at 2:40 PM, documents "(R2) has been anxious this day, pacing the hallway and voicing that she does not understand why she is here, she fears her family may be sick and why did they leave her here. She asks for mom and dad. Resident's POA (Power of Attorney) came to visit resident and resident became very upset and crying. R2's Nurse Progress Note, dated 10/7/2024 at 12:29 AM, documents "1 milligram (mg) Ativan administered for increased anxiety." R2's Nurse Progress Note, dated 10/7/2024 at 2:21 PM documents "(V6), Medical Director documents (R2's) primary diagnosis is Alzheimer's disease. Currently she is generally awake, alert and pleasant, however she is adamant about going home, she cannot understand why she is here at the facility. (R2) is becoming increasingly forgetful and in addition she has had a problem with anger outburst and very hostile behaviors which previously were out of character for her."	S9999		

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R2's Skilled Nursing Admission Documentation, dated 10/8/2024, documents "alert to person only and confused. (R2) was assessed independent with bed mobility, transfers, eating and toilet use. A note documents: resident alert to self, able to make needs known. Resident anxious this morning, carrying her purse saying she needs to leave, becoming agitated. PRN (As Needed) Ativan administered and effective. Ambulates independently, with steady gait."

R2's Nurse Progress Note, dated 10/10/2024 at 2:03 PM, documents "(R2) continues to seek exit today and asking for (V12) and husband able to redirect at this time.

R2's Nurse Progress Note, dated 10/11/2024 at 1:01 AM, documents "(R2) had an episode prior to HS (bedtime) that was long lasting where she was exit seeking and yelling out for her daughter, staff unable to redirect easily and PRN Ativan was given. She calmed after about an hour and the PRN dose was effective. Closely monitored by memory care staff."

R2's Admission Minimum Data Set (MDS) dated 10/11/2024, documents resident understood and understands. Brief Interview for Mental Status (BIMS) score of 5 (severely cognitively impaired.) Physical, verbal, and other behavioral symptoms (hitting or scratching self, pacing, rummaging or verbal/vocal symptoms like screaming, disruptive sounds) occurred 1 to 3 days. Rejection of care occurred 1 to 3 days. Change in behavior or other symptoms were worse. No mobility devices.

R2's Nurse Progress Note, dated 10/14/2024 at 2:00 PM, documents "completed the admission MDS and assessment with (R2). (R2) is confused as to time, place and situation. (R2) was able to

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answer the MDS questions without issues. The questions about her history were a little more confusing for her. She is new to the facility and is on the unit. She packs her belongings every day and waits for (V12) to pick her up. (R2) was able to talk about her past and growing up. We will continue to try to get her involved in activities."

R2's Nurse Progress Notes, dated 10/15/2024 at 6:40 PM, documents "(R2) returned to facility via EMS via stretcher. (R2) alert and oriented to self. Speech clear. No injuries observed from previous incident. (V8), Medical Director notified of (R2's) return."

R2's Admission Assessment, dated 10/15/2024 at 6:40 PM documents "elopement risk assessment walk in room supervision on and off unit, moderately impaired decisions regarding tasks of daily life, behaviors include: prior exit seeking, packing belongings, repeatedly opening doors/settings off alarms of secured doors, resisting redirection from staff and verbalizing statements about leaving. Contributing diagnoses include Alzheimer's disease, depression and anxiety disorder. Interventions documented include ID bracelet on, clothing marked with identification and frequent checks."

R2's Nurse Progress note, dated 10/15/2024 9:42 PM, documents "frequent checks on resident."

V7, CNA Written Statement, dated 10/15/2024 at 5:15 PM, documents "I was on the hall working and was last in contact with (R2) around 4:00 PM. She asked about going home and I instructed her we would have dinner in about 30 minutes if she could wait. I then checked on another resident and then moved onto another resident and escorted her to the bathroom where I then began

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to change her. I was notified of (R2) being gone around 4:45 PM."

V4, LPN Written Statement, dated 10/15/2024 at 5:44 PM, documents "this nurse had just finished med pass on a (different hall than R2 resided) hall, med cart parked at nurse's station when phone rang. (V9), Unit Aide answered phone at 5:40 PM. (V9) informed this nurse that police were on the phone and (R2) was in their custody, they had found her in a field and (V9) transferred the call to Administrator's office. This nurse immediately went to Administrator's and DON's offices to notify them. This nurse then went to (the hall R2's room was located) hall, head count performed. All residents accounted for except (R2)."

V9, Unit Aide Written Statement, dated 10/15/2024 at 6:00 PM, documents "I, (V9) was passing supper when the phone rang at 4:50 PM. I answered the call from the local police department who stated they found one of our residents in a field. I made the resident's nurse aware the Administrator the police were on the phone."

R2's Care Plan, updated 10/16/2024 documents focus: the resident is at risk for elopement posing a safety concern. Goal: the resident will not leave the facility without a responsible person accompanying them. Interventions: develop a plan for immediate action if elopement occurs. Educate the family and engage resident in activities such as folding washcloths/towels, washing tables in dining room to give a sense of purpose. Have photo and description readily available. Implement continuous monitoring and whereabout tracking preform elopement risk assessment on admission and quarterly secure

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exits, windows and potential escape routes changing codes to locked unit train staff of elopement prevention and immediate response.

V1, Administrator typed statement dated 10/16/2024, documents "this writer was informed around 4:30 PM on 10/15/2024 from the local Sherriff's Office that someone had called the sheriff's department about a person that was observed at the corner South Grand and Harrison Street. Resident had been sent to local hospital Resident did return from hospital at 6:40 PM. Hospital stated no injuries. This writer also spoke with (V12) to keep her updated and told her (R2) had returned from hospital. Prior to (R2's) returning to the facility, facility provided POA information at 5:07 PM on the 15th. This writer informed the Medical Director of incident that same day. Investigation continues. 10/16/2024 left message for IDPH (Illinois Department of Public Health) to return my call. Informed my receptionist of this. On 10/15/2024 Administrator had maintenance screw all the windows on (hall R2 resides on) hall to only open 2-3 inches. There was a window left open in a vacant room. On 10/16/2024, DON and Administrator surveyed the area where (R2) was observed at. Maintenance and Administrator also surveyed the grounds of the facility with no real findings. Spoke to (V14) at 11:00 AM on 10/16/2024, Assistant Director of Nurses at hospital to thank her and the hospital for the assistance with (R2)."

On 10/17/2024 at 9:00 AM, R2's door was closed. Upon opening R2's bedroom door she was observed sitting on her bed with a black purse next to her. R2 told the State surveyor she wanted to go home, and she doesn't belong here, and she didn't know where her family was. R2 didn't recall being outside or at a hospital within

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the last few days and she was alert to name only at that time. No identification bracelet on."

On 10/17/2024 at 11:20 AM, V3 Social Service Coordinator stated that (R2) was initially admitted on 10/4/2024, (R2) was very confused and thought this was a doctor's office and as soon as she was seen by the doctor she could go home. (R2) is severely cognitively impaired and wanders up and down the memory locked unit hall from one door to the other and constantly tries to get out of the locked unit. V3 didn't see or assess (R2) on 10/15/2024 and wasn't told (R2) was exhibiting behaviors on that day. Upon admission, (R2's) family told her (R2) is no longer safe to be at home because her husband is frail with a heart condition and can't take care of (R2) anymore and she was afraid (R2) would leave the house unsupervised and would get harmed in some way. (R2's) family voiced they were afraid she would get out of the facility and get harmed in some way.

On 10/17/2024 at 12:20 PM, V4, LPN (Licensed Practical Nurse) stated she worked on 10/15/2024 and was assigned to (R2) from 6:00 AM to 6:30 PM. V4 states she works with 1 CNA (Certified Nurse Aide) on the memory care locked unit and she is also assigned to other residents on three additional halls so although she is the assigned nurse to the locked unit, she is not back on the locked unit at all times when she is off the unit administering medications to other residents there is 1 CNA assigned to the unit for 11 residents who are very active and multiple residents are ambulatory and have behaviors and it is hard for her and the CNA to keep track of the residents let alone her being off the unit and leaving 11 residents with 1 CNA. Staffing has been like that for the year she has worked at the

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facility and even though she doesn't agree with it, it's how her schedule is set for the day to be assigned to multiple halls. V4 recalled she administered morning medication to (R2), and she took it, but she didn't recall seeing (R2) after that. V4 left the locked unit between 3:25 PM - 3:30 PM to pass evening medications on other halls and didn't recall seeing the resident at that time. V4 found out the resident was not at the facility at approximately 4:50 PM on 10/15/2024 because she was on a hall passing evening medications and overheard (V9) talking to the police on the phone and when (V9) transferred the call to (V1), (V9) told her that (R2) was in police custody, and she was found walking in a field. When she found out (R2) eloped she went to the locked unit she went and did a head count she noted the window (in R2's room) was wide open and a recliner was propped up against the window as well. All residents were accounted for at that time except for (R2). V4 didn't know how (R2) got out of the facility or if (R2) went out the window. V4 stated she never observed (R2) playing with the windows on the locked unit or anything like that.

On 10/17/2024 at 1:30 PM, V7, CNA stated he worked on 10/15/2024 from 6:00 AM to 6:30 PM and was assigned to (R2) on the locked unit. V7 was the only CNA assigned to the locked unit with (V4), LPN and when (V4) had to administer medications to residents on other hall V7 was the only employee assigned to the locked unit. V7 stated he was getting residents ready for supper and that consists of toileting residents and washing their hands. V7 assisted (R2) to the bathroom and the last time V7 saw (R2) was at 3:00 PM. V7 stated he didn't know (R2) was not at the facility until (V4), LPN came and told him to do a head count of residents because the police

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called and reported (R2) was found walking in a field and was in police custody. V7 assisted with the head count and (V4) showed him a window in room 300 was wide open and a recliner was propped up against the window. V7 stated there are 4 or 5 residents that are exit seekers and several are transferred via sit to stand lifts, so they need 1:1 care he has to stay there with them. V7 stated he didn't hear any door alarms while he was caring for the residents in the bathroom. While he provides 1:1 care he tries to make sure all residents are safe prior to going into the bathroom but he's only 1 person and can't leave a resident on the toilet alone so he does the best he can. No other staff are there to keep an eye on the residents when he is providing 1:1 care to a resident. V7 stated he was familiar with (R2) and her wanting to always go home but she was calmer the day of 10/15/2024, she still voiced she wanted to go home but she wasn't hanging out at the exit door like she has in the past. V7 stated (R2) is alert to name only and she is extremely confused at all times. When she exit seeks and says she wants to go home V7 tells her let's eat the next meal and go from there to redirect her. V7 recalled what (R2) wore on 10/15/2024, it was pants with a t-shirt with a sweater over the t-shirt and house shoes.

On 10/17/2024 at 11:40 AM, V10, Activities/Unit Aide stated she worked on the locked unit on 10/15/2024 and left at 3:00 PM and (R2) was on the unit at that time because she recalled saying bye to her. V10 was familiar with (R2) and stated (R2) always says she's going home and she's always packing her bag. V10 stated (R2) looks out the windows often but she never saw her playing or attempting to open a window.

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On 10/17/2024 at 11:05 AM, V2, DON stated that (R2) was admitted on 10/4/2024 and "ever since then she has wanted to go home every minute of every day." V2 knew (R2) wanted to go home prior to her eloping from the facility. (R2) was initially admitted to the facility on the memory care locked unit due to her diagnoses of dementia and early onset Alzheimer's disease. V2 stated (R2's) family was concerned (R2) would leave the facility without anyone knowing and get harmed in some way. Prior to (R2) eloping the facility she expected staff to encourage (R2) in social activities on the unit, assist with activities and monitor for worsening behaviors. After (R2) returned from the elopement she expected staff to reassess her elopement risk to see if it changed and she wasn't aware staff didn't document a reassessment of (R2's) elopement risk. Interventions that were added to (R2's) care plan after she returned to the facility included in-servicing staff on how to prevent future elopements, educate family, involve the resident in folding wash cloths and towels, 15-minute checks for 72 hours and increase monitoring of resident as needed. Staff working on the memory care locked until on 10/15/2024 reported seeing (R2) last at 4:00 PM that day. She was aware after the police called the facility at approximately 4:40 PM that the resident was found walking in a field behind the hospital, she didn't know how the resident got out of the facility. After she was aware (R2) eloped she had the memory care locked unit do a head count to ensure all other residents were there and the nurse noted a window (in R2's room) was wide open and there was a recliner pushed against the windowsill. On 10/17/2024 at 1:10 PM, V2 stated an elopement risk assessment should be completed after a resident elopes to see if the elopement risk has changed. There is no initial care plan done upon

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a resident's admission and a MDS is done at days 4 and 14 then a care plan is documented at day 21 after a resident is admitted. The memory care unit is a locked unit for confused residents and there is 1 nurse and 1 CNA assigned to the unit. The nurse is also assigned to other halls as well so she's not always on the unit, but the assigned CNA is always on the unit. There are 11 residents that reside on the locked unit with 4 of the 11 residents are ambulatory and V2 didn't know how many residents exit seek or set door alarms off. (R2) was readmitted the same day she eloped which was 10/15/2024. (V2) was not at the facility when (R2) was readmitted to the facility via EMS but she knew (R2) didn't sustain any injuries.

On 10/16/2024 at 1:30 PM, V5, Maintenance Man stated he just started working as the maintenance man at the facility, before that he worked in the kitchen. V5 was aware a resident was found in a field a few days ago but didn't know how she got out of the facility. The Administrator asked him to screw all the windows shut so they only open approximately 2 inches one day after (R2) was readmitted to the facility.

On 10/17/2024 at 10:50 AM, V1, Administrator stated she was here at the facility on 10/15/2024 from approximately 8:00 AM to 6:30 PM. She was not aware (R2) was missing from the facility until the police called the facility at approximately 4:30 PM on 10/15/2024 and they stated the resident was found walking in a field near the local hospital. V1 stated doesn't know how (R2) got out of the facility or what time she left the facility. (R2) was seen by a staff member at 3:00 PM on 10/15/2024 and that was the last time staff saw here before she eloped. After V1 was notified that the resident was not at the facility staff did a head

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	IL6015895	A. BUILDING: _____ B. WING _____	C 10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR HEALTH CARE	485 SOUTH FRIENDSHIP DRIVE NASHVILLE, IL 62263

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count on the memory until and during that it was noted a window in (R2's room) was found wide open with a recliner pushed up again the heat register. V1 and other staff don't know if (R2) went out the window to get out of the facility but since then they have screwed the windows shut on the memory unit so the windows only open 2 inches so residents cannot go out the window. (R2) was transported via EMS to the hospital and then back to the facility at approximately 6:30 PM on 10/15/2024 with no injuries. (R2's) has a low BIMS score and has diagnosis of dementia and early onset Alzheimer's disease. V1 stated R2 was found wandering in a field 0.6 mile from the facility. Review of the streets surrounding the facility showed there were multiple cars driving by a curvy busy country road with no sidewalks and deep ditches on both sides of the road. There was also a pond within 150 feet of where the resident was found. (R2) was initially admitted to the facility on 10/4/2024 and since then she's stated she wants to go home and that's why she's on the memory locked unit because she doesn't have safety awareness and to be kept safe. When (R2) states she wants to go home she expects staff to redirect her. Since she returned to the facility staff have (R2) on 15-minute checks for 72 hours and all residents every 2 hours for 72 hours.

On 10/18/2024 at 8:46 AM, R2 was observed sitting on her bed dressed with house shoes on. She was packing her clothes into a plastic hospital bag and stating to call her family because she needs to go home today. No identification bracelet on.

On 10/18/2024 at 9:00 AM, R2 was observed sitting on her bed her house shoes were under the bed and she now had tennis shoes on. R2

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again stated tell them I am going home today and to call her family. No identification bracelet on.

On 10/18/2024 at 10:48 AM, V8, Police Officer who responded to the 911 call stated no report was made for this incident because he saw it as a medical situation. 3 police officers responded to an elderly woman (R2) walking in a bean field behind the local hospital on 10/15/2024 at 4:31 PM. The resident stated her last name and police dispatch called the local nursing home and they stated the resident resided at the facility and they didn't know she was missing. The resident was pleasantly confused at that time and had notable dementia. V8 couldn't recall what (R2) was wearing or if she had shoes on or not. (R2) was transferred to the local hospital via EMS at that time. No police report was documented because this was considered a medical transport issue.

On 10/18/2024 at 9:05 AM, V6, Medical Director stated that (R2) is alert to person only and has poor safety insight. (R2) has diagnoses including dementia and early onset Alzheimer's disease. (R2) is not safe to be outside by herself due to poor safety awareness due to being confused and has anxiety often. V6 stated (R2) never wanted to be at the facility and her family told her once the doctor sees her, she can go home, and she continues to say she wants to go home. V6 didn't know how (R2) eloped from the facility but thinks she followed a family out the locked door and went out the main door of the facility. V6 wasn't aware there was a window left wide open in room 300 on the locked unit after the resident eloped.

On 10/25/2024 at 2:00 PM, V1, Administrator stated (R2) now has a Electronic wandering bracelet on her ankle. V1 stated the facility had

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the electronic wandering system in place when (R2) was initially admitted to the facility but no one put the Wander Guard bracelet on her. V1 expected staff to assess all new residents for elopement risk and if they are determined to be an elopement then an electronic monitoring bracelet should be applied within hours of the resident being admitted to the facility. The memory care locked unit doors are not equipped for the electronic system, but all other exit doors to the facility are protected so if (R2) had the electronic wandering bracelet on, the alarm would have sounded.

The Facility's Undated and Untimed Final Investigation documents "(V2) was notified on 10/15/2024 at or around 4:30 PM that the local Sheriff's Office had responded to a call regarding an individual in the area of South Grand and Harrison Street In Nashville, Illinois. This individual was identified as (R2) a memory care resident of the facility. Sheriff's Deputies transported (R2) to the local hospital per department policy, Facility investigation began Immediately and (State Survey Agency) and the facility Medical Director were notified. Facility shared pertinent medical Information regarding the resident with local hospital, including the power of attorney Information on file at the facility, at or around 5:07 PM on 10/15/2024. The resident's family was immediately notified of the elopement and was notified again when (R2) returned to the facility at 6:40 PM on 10/15/2024."

The results of the investigation are as follows:

(R2) was observed by staff safe and secure in her assigned room on the locked memory care unit of the facility at 4:00 PM on 10/15/2024. Following the notification by the Sheriff's Department of the

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discovery of the resident at 4:30 PM, the facility conducted a search of the memory care unit and discovered a window ajar in an unoccupied resident room on the unit. While a conclusive determination cannot be made with the evidence at hand, It Is suspected that (R2) exited the facility by 1 of the 2 methods: 1. Following the check on (R2) 4:00 PM she may have at some point entered the unoccupied room on the locked memory care unit and was able to open a window and exit the facility. 2. (R2) followed a visitor through the unit's secured door, with the visitor not being aware that she was a resident. She was then able to exit the facility. A search of the facility grounds and the area that the resident was found revealed no additional findings. (R2) sustained no injuries as a result of the elopement. Facility staff have been reeducated on elopement policies and procedures. The door codes to enter the locked memory care unit of the facility have been changed and distributed to staff. A new notification system has been Implemented for families to utilize to gain entry to the locked memory care unit with posted Instructions at the entrance. The facility maintenance department as inspected all windows along the locked memory care unity of the facility as has modified their operation to only allow for the window to open 2-3 Inches, per life safety codes. (R2's) care plan was updated to reflect her current status and to include the use of a Wanderguard device which was Implemented Immediately. Beginning on 10/15/2024 all memory care residents were put on 15-minute checks to continue for a period of 72 hours. Upon the expiration of the 72 hours, (R2) wlll continue to be on 15-mInute checks while other residents will be on 2 hour checks for a continued period of-14 days and then QA Team will review. All residents of the memory care unit were reevaluated for elopement risk and statuses

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were updated accordingly. Elopement policies and procedures, and this incident in particular will be included in the next QA meeting to be held on 10/20/2024.

R2's Hospital Emergency Department documentation dated 10/15/2024, documents chief complaint: patient presents with altered mental status. 83-year-old female patient resident of local nursing home for the past 5 days only with a past medical history of dementia, high blood pressure, high cholesterol and anxiety who was found wandering in a field in heavy clothing with house shoes and socks, carrying one shoe in her hand. Patient was found by a passerby who noted that patient was confused so 911 was called. Police found out that patient was a resident of local nursing home and patient was not able to say where she lived. EMS transported to ER for evaluation. We called nursing home to request paperwork and information about contacting family. We called (V12) for more information and found out that patient was just placed into the nursing home on Friday, and she had been trying/wanting to leave ever since. Previously patient was at home being cared for by her 89-year-old frail husband. (V12) not able to come to ER because she was taking the patient's husband to the ER for another health matter. Physical exam: awake, alert, confused, asking about parents and her missing daughter. Neurological: mental status: she is alert. Mental status is at baseline. She is disoriented and confused. Psychiatric: perception is normal, she is inattentive. Thought content is delusional. Cognition and memory is impaired. She exhibits impaired recent memory and judgement is impulsive and inappropriate. Medical Decision Making: 83-year-old patient with dementia found wandering in a field several blocks from nursing

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home where she is a new resident in the locked dementia unit. Patient found walking by a passerby and when patient was confused, they called 911. Patient checked over with no physical abnormality noted. Patient ambulatory with steady gait and had no complaints of pain, nausea, dysuria, fever or any other complaints. Patient was disoriented which (V12) confirms is her baseline. Problems addressed: confusion: chronic illness and dementia. Risk details: called patient's (V12) to discuss findings and the decision to discharge. (V12) unable to come get patient because she is with patient's husband in another ER right now. Decision made to use EMS for transport due to high elopement risk via other means as evidenced by her escape from locked unit in the nursing home and her baseline severe dementia confusion.

The facility's Elopement Prevention Policy, dated 1/1/2024, documents the facility will implement individualized interventions to strive to prevent elopement. We define elopement as follows: a situation in which a resident leaves the premises or a safe area without the facility's knowledge and supervision, if necessary. Procedure: upon admission, quarterly, and after an elopement event or attempt, and with a change in condition, each resident will undergo a comprehensive elopement risk assessment using a validated tool. Assessment results will be documented in the resident's medical record and used to develop an individualized care plan for residents identified to be at risk for elopement. The interdisciplinary Team (IDT) will work with the resident and/or family to identify and implement appropriate individualized elopement prevention interventions based on assessment findings to reduce the risk of elopement while maximizing dignity and independence. Interventions may include but are

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S9999	Continued From page 18 not limited to electronic monitoring/alarm system, environmental modifications, protected list of names and photographs of those at risk for elopement, psychosocial interventions, regular rounds, resident/family education, staff interventions, and structured group activities. Communicate interventions during shift report and daily clinical rounds to the caregiving team. Review and revise the elopement plan of care admission, quarterly and after an elopement event or attempt and with a change in condition. The IDT will educate residents and their families about fall risks and prevention strategies. Analyze elopement incident date to identify trends and develop quality improvement initiatives. Provide regular training for all staff on elopement prevention, risk assessment, and post-elopement event management. Ensure staff competency through ongoing education and practical assessments. The QAPI Committee will review elopement incidents and outcomes regularly to ensure compliance with the policy and identify areas for improvement and implement quality improvement projects based on data analysis and feedback from staff and residents. (A)	S9999		