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S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.690a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3) 300.3100d)2) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease 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.	S9999		

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S9999	Continued From page 1 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. 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders,	S9999		

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and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition.

Section 300.3100 General Building Requirements

d) Doors and Windows

2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required.

These requirements were not met as evidenced by:

Based on observation, interview, and record review the facility failed to provide adequate supervision for a cognitively impaired resident, known to exit seek, and with a prior elopement history, to prevent an elopement. The facility also failed to complete a full body post-elopement assessment to determine injury, failed to develop an elopement care plan with interventions in a timely manner, and failed to ensure functional exit door alarms. These failures resulted in R1, a severely cognitively impaired resident at risk of falls and receiving anticoagulation therapy, exiting the facility without staff knowledge or supervision, walking approximately 0.4 miles in extreme cold

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weather down a busy street. R1's likely path included steep ditches and large rocks. These failures affect one of three residents (R1) reviewed for elopement on the sample list of 14.

Findings include:

R1's Census record documents R1's initial admission to the facility was on 12/27/24.

R1's Diagnoses sheet dated 12/27/24 documents the following: Dementia in Other Diseases Classified Elsewhere, Severe, With Mood Disturbance, Delirium Due to Known Physiological Condition, Restlessness and Agitation, Hypertension, Paroxysmal Atrial Fibrillation, Muscle Weakness (Generalized), Unspecified Abnormalities of Gait and Mobility, and Other Lack of Coordination.

R1's Physician Order Sheet (POS) dated 12/27/24 - 1/9/25 documents the following: Eliquis (anticoagulant) Oral Tablet 5 (five) milligram (mg), Give 5 mg by mouth two times a day for Atrial Fibrillation, Metoprolol Succinate ER, Oral Tablet Extended Release 24 Hour, 50 MG every day for Hypertension and Spironolactone Tablet 25 MG, Give 1 tablet by mouth one time a day for Hypertension.

R1's Minimum Data Set (MDS) dated 12/31/24 documents R1 is severely cognitively impaired and R1 has a history of falls before and after admitting to the facility.

R1's Admission Assessment (Baseline Care Plan) dated 12/27/24 documents R1 has had falls prior to admission, R1 has an unsteady gait and sitting balance, and R1 is at high risk of falls.

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R1's Elopement Evaluation dated 12/30/24 documents R1 that has the ability to leave the building, R1 is not considered independent for outside pass privileges, and R1 has been noted at exit doors or wandering. R1's Care Plan was not updated to include a concern for elopement until 1/1/24.

R1's Nurse's Note dated 12/30/2024 at 04:13 am documents, "Resident still up and not staying seated. Resident wandering and exit seeking. Resident pushing on exit doors. Redirected but continues."

R1's 72 hour Charting Follow-Up Late Entry Note dated 1/1/25 at 10:42 AM (fall 12/30/25) documents "(R1) Follow-up assessment post-fall." "Resident is alert and disoriented per usual baseline. No new injuries noted on assessment. No pain. No changes noted in ROM (range of motion). Bed in lowest position. Monitoring for behaviors. Call light in reach. Non-skid socks/ footwear in place, increase monitoring, (departure alert device), and 1:1 (one on one). No skin issues noted. No bruising noted. No s/s (signs or symptoms) of infection noted to site. No swelling noted. Fall Follow up assessment post-fall."

R1's Nurses Notes dated 12/30/24 at 11:40 pm document, "Resident alert but confuse(d) and disoriented. Respiration even and non-labored. Speech clear. Appetite good and drink fluids well. Needs assist with ADLs (Activities of Daily Living). Can be combative when agitated. Uses wheelchair for mobility. No complaints made from fall. Continue(s) to get out of bed or chair by himself and at times cannot be dissuade. Very unstable when on his feet. High risk for falls. Concern for a need for one on one monitoring

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made known to DON (V2, Director of Nursing) and Administrator (V1)."

R1's Behavior Note dated 12/31/2024 at 12:21 am documents, "Resident noted to be combative and aggressive with CNA (unidentified Certified Nursing Assistant) when attempting to assist resident. Resident grabbed CNA in collar while she was attempting to help resident back in his wheelchair. Shortly after resident attempted to elope via south hall exit. Resident was able to open the door and step outside before the nurse (unidentified) on duty was able to catch him. Resident began to resist staff attempting to re-direct him from the exit. Resident ask this writer if she had called the police for him, he was being held against his will and needed the police to rescue him. Resident was informed he was placed in the facility for assistance with his care by his family and he was not being held hostage but receiving health care. Resident was assisted back to the nursing station where he is currently sitting."

R1's Admission Assessment dated 12/30/24, signed by V3, Nurse Practitioner documents R1 has a baseline altered mental status and is non decisional and R1 had a fall over the weekend without any noted injury. V3's Assessment documents, "(R1) has a history of impulsivity since admission (12/27/24) to the facility, crawling in his room, and requiring frequent observation with fall mats at bedside. He has also been wandering and exit-seeking, with potential placement on a (departure alert device bracelet) per (V2, Director of Nursing) DON and clinical staff." The same assessment directs staff to provide "Frequent observation."

R1's COMMUNICATION- with Family/NOK/POA

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(Power of Attorney) dated 12/31/2024 at 1:48 am, signed by V3, Licensed Practical Nurse (LPN), documents, "Resident sent to ER (emergency room) for evaluation and treatment as needed due to resident falling, hit his head against wall resulting in him biting his tongue. Resident tongue purple in color. Resident states his tongue is painful 10/10 (on a scale of one to ten equals extreme pain). (V6, Assistant Director of Nursing) ADON was made aware of resident incident and state(d) send resident to ER due to being on anticoagulant (blood thinner). MD (V7, Medical Director) made aware of incident at 1:07 am. Call attempted to POA (V13, R1's Family Member) 01:13 am at (private number), voicemail not set up unable to leave message. Nurse to nurse report given to (V4, Registered Nurse) at (local Hospital). Emergency service contacted at 1:20 am, arrived at 01:30 am. Resident noted to be confused in regard to the details of the incident. Nurse (unidentified) on duty, who was at the nursing station where the incident took place, states the resident was standing up adjusting his jacket and fell back hitting his head against the wall. This writer (V30, LPN) had just walked off from the resident assisting him back into his chair."

R1's Nurse's Note dated 12/31/24 at 3:35 pm documents, "Resident POA (V13, Power of Attorney) here, and made aware of resident being sent to (local hospital). Resident has been anxious this shift. Resident has been up ambulating this shift. Resident (V13, Family Member) here most of shift. Resident reminded most of shift to sit in w/c (wheelchair). Resident became agitated with writer after (V13, Family Member) left. Resident has been confused. Resident took all meds (medications) whole without difficulty."

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R1's Incident Note dated 01/01/25 at 5:30 pm, signed by V8, Registered Nurse (RN), documents "Resident was observed ambulating outside the facility. CNA (V15, Certified Nursing Assistant) went to get resident to come back inside the building. No distress noted. No injury noted. POA (V13, Family Member), MD (V7, Medical Director), DON (V2, Director of Nursing) and Administrator (V1) notified. Resident placed on one on one monitoring (alarm bracelet) placed to left ankle. Will continue to monitor."

R1's one on one supervision sheet is dated as initiated 01/01/25 at 5:30 pm.

On 1/9/25 at 7:15 am V8, Registered Nurse (RN) stated, "The evening (R1) got out and walked down (Street Name) Avenue, I think it was the 01/01/25. A passerby called the facility and said we had a confused resident walking in the middle of the street, over by the apartments. The passerby said he (R1) did not have on a coat. It was pretty cold day. I can't remember if it snowed yet, but I think it may have. There was snow when I left my shift. (Street Name) Avenue traffic gets very busy during evening rush hour. The CNA (V15, Certified Nursing Assistant) went right away to go find him (R1). (R1) was always trying to go somewhere. He was consistently exit-seeking. He would shake the exit doors whenever I worked. He had never gotten far out of the building when I had him (was R1's nurse). I had not seen (R1) for a quite a while that evening. I am not sure how long he was gone. Nobody had seen him for about an hour. I asked everyone. I figured it was probably (R1) the passerby saw. None of us working heard an alarm go off. We had no idea how he got out of the building, or how long he had been gone. I ended up telling (V12, Maintenance

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Director) to look at the cameras to find out which door (R1) went out because nothing triggered an alarm when he (R1) left. I admitted (12/27/24) him (R1) and did not know he was an elopement risk at time. He was admitted with A-Fib (abnormal fast heartbeat) and had a history of falls. It was evident within a day or two of admission he was an elopement risk. He was not a one-on-one until 1/1/25 after he was found outside walking in the street. We put a (departure alert device) on him at time too. When (V15, CNA) brought him (R1) back to the facility, he (V15, CNA) said he did not see any injuries. (V15, CNA) said (R1) was very cold and warmed up in (V15, CNA's) car." V8, RN stated "I did not complete a full body assessment, vital signs or neurological assessment when (R1) returned to the building. I did not complete an accident report, or risk management report. The incident note you have is all I had time to do. I was working a hall and a half (of residents) and training a new nurse. Now I think about it, he (R1) had several falls in the facility. He came to us with a history of falls. He could have had a fall outside when he eloped evening (1/1/25). He used a wheelchair, and we were constantly reminding him not to stand up. He had a very unstable gait. I should have completed a thorough assessment, just like we do when a resident has an unwitnessed fall."

On 1/9/25 at 8:55 am V13, R1's Family Member stated, "(The facility) has called me (V13) four times about (R1) exiting the building. Three times, I was told he was just outside the doors. Once he walked right out the front door. The other times he went out the side doors. One time they reported he was found walking down (Street Name) Avenue. I was not thrilled about. It was 20 degrees (Fahrenheit) outside. I did not

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understand how could happen if he was adequately supervised. He can't walk steady and is in a wheelchair. How could he get all the way to (Street Name) Avenue and have been walking. He has had a couple falls before and after being at (the facility) trying to walk."

On 01/9/25 at 4:45 pm R6 stated R6's room and R1's room, share a bathroom. R6 stated R1 was confused and repeatedly came in to R6's room and yelled for R6 to get out of R1's house. "Staff were supposed to be watching him. Half the time the staff were visiting with each other down the hall, nowhere near his (R1) room. I saw with my own eyes several times. They did nothing to keep him out of my room. I finally put a chair against the bathroom door so he would stop coming in. He was supposed to have a sitter with him all the time. They obviously were not keeping a good eye on him."

On 1/9/25 at 1:35 pm V12, Maintenance Director stated he had reviewed the cameras to determine which doors R1 left from on each elopement attempt. V12 stated, "The first time he went out on 1/1/25, he went out the west door. He had a heavy coat and shoes on. He left his wheelchair at the door. A CNA (unidentified) saw (R1's) chair (wheelchair) at the exit. The CNA was talking to (V8, Registered Nurse). They (unidentified CNA and V8, RN) saw out the window, as (R1) was walking past the window. They both ran out the west hall door and brought him back. The second time, the same day (1/1/25), he had sweat pants and a tee shirt on, and no coat. (R1) went out the smoking door and pushed open the emergency gate off the patio (this fall R1 walked down (Street Name) Avenue). On 1/6/25 he went out the west wing exit door. (V8, RN) and a CNA (unidentified) went out immediately and brought him back in.

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His next elopement on 1/7/24, he could be seen fighting with staff at the west door. Five staff exited the building and stayed with him until the police came. I will give you a timeline from the cameras."

On 1/9/25 at 3:10 pm V12, Maintenance Director provide the timeline of R1's four elopements from the facility, which confirmed V12's interview account of the elopement incidents noted above.

On 1/1/25 R1 was dressed in heavy coat, blue jeans, and shoes at 8:58 am when R1 exited the facility via the west wing door, leaving his wheelchair at the exit.
* At 8:59 R1 could be seen on the facility camera walking northbound on the sidewalk.
* At 9:02 am R14 sees R1's wheelchair and looks at the exit door.
* At 9:03 am (unidentified receptionist) shuts off the alarm.
* At 9:04 am R14 alerts staff (unidentified) to the wheelchair.
* At 9:05 am R14 talks to V8, Registered Nurse (RN).
* At 9:06 am R1 walks south, past the windows. (unidentified CNA) and V8, RN rush out West door.
* At 9:07 am (unidentified CNA) brings R1 back into the facility. V27, CNA moves a spare hospice bed in the hallway, over to the entrance, for R1 to sit down on while the unidentified CNA goes to get R1's wheelchair. R1 taken to his room.

On the same day 1/1/25 R1 had a second elopement timeline documents:
* At 4:35 pm R1 was in the west wing dining area.
* At 4:42 pm R1 went out the smokers door, to the patio and rolls to the north gate.

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* At 4:44 pm R1 pushed the emergency north side gate open. R1 went out of the gate wearing sweatpants and tee-shirt.
* At 4:47 pm Unidentified male CNA possibly shut alarm off. V12 stated the male CNA walked in the direction of the key pad to shut off the alarm but could not actually be seen entering the code.
* At 4:50 pm (eight minutes after R1 exited the building, by this timeline) V53, Receptionist takes a phone call and alerts an unidentified staff member.
* At 4:59 pm V15, CNA grabs his own coat.
* At 5:02 pm V15 and V38, CNAs go out the front door.
* At 5:06 pm R1 is brought back via front door by V15 and V38.
* At 5:08 pm V15, CNA and V8, RN were trying to determine R1's exit door location.

V6 Assistant Director confirmed there is no progress note or assessment documentation of R1's elopement in R1's medical record correlate to the first elopement 1/1/25 on above time line.

On 1/9/25 at 4:05 pm V15, Certified Nursing Assistant stated, "I was the person went to get (R1), I think it was on the first (January 1, 2025). Supper trays had not been delivered yet. A woman (unidentified) called the facility. The woman said she saw a guy walking in the middle of the street, on (Street Name) Avenue. She said the guy was down by the (Name) apartments. The (Name) apartments are about a half mile down the road. (Street Name) is a busy street. It happened during rush hour traffic too. I could have guessed it was (R1), but we didn't know for sure, yet. I had not seen him for a while because he goes all over the place in his wheelchair. It was around 4:30 pm the last time I saw him. He was notorious for shaking the exit doors and

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trying to leave. He was an exit seeker for sure before. Everybody knew it. I should say, I knew it. I can't speak for what other people knew. They should have known it, is what I will say. He would rush the door and say he needed to leave. He has done since he was admitted (12/27/24). We usually hear the door alarms sound and get to him before he gets too far out the door. That evening, no door alarm sounded. We had no idea what door he went out, or how long he was gone. I left (the facility) and drove down (Street Name). Traffic was heavy. I got down by the apartments. He (R1) was walking down the north bound lane. He was not in the center of the street. He was in the center of the north bound lanes. He was about four feet from the curb when I saw him. Traffic was going around him. I stopped in the street, so all the traffic went around my car, instead of him (R1). I got out of my car and went to get him. I don't know what the temperature was, but I was cold just getting out of my car. (R1's) arms were red and he (R1) said his hands were getting numb they were so cold. He was just in a short sleeved tee-shirt and had no coat on. He was really, cold. The lady that called was parked in the apartment drive. She said she talked to him, and noticed he seemed very confused that it was why she called. She thought it could be a resident from (the facility). I had my heat turned up as high as it could go. (R1) thanked me for picking him up and wanted me to take him to some address in Danville. I worked with him a lot and know he has dementia. I told him I would like him to come with me and warm up first. He did not have any behaviors for me, then or ever. I have heard he has been aggressive with other staff. Never for me. I have a lot of experience working with dementia residents. Most often they can be distracted with an activity or food. I found both worked for (R1).

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We got back to the facility and sat in the car for a couple more minutes, so he was good and warm. He (R1) was cooperative when I turned him over to (R8, Registered Nurse/RN). (V8, RN) asked if he was hurt. I told her (V8, RN), he (R1) was cold, but I didn't notice if he had any injuries. (R8, RN) took it (assumed R1's care) from there. I don't know if she did vitals or anything. I went on to get supper trays served. It was close to 5:30 pm which is normal time for supper trays to come up." V15, CNA stated, "I later heard (R1) went out the smoking area doors. That door alarm has not worked right for a while. You just push on the bar for a couple of seconds, and it opens without the alarm sounding. Somebody is usually at the nurse's station and can see door if people go out to smoke. After this elopement they put a (departure alert bracelet) on (R1's) ankle and made him (provided R1) a one on one (constantly supervised by one staff). I was his one on one several times since, and never had a problem distracting him if he started exit seeking." V15, CNA agreed to show this surveyor the area R1 would have likely traveled, to where V15, CNA found R1 in the street 1/1/25.

On 1/9/25 at 4:14 pm V1, Administrator confirmed R1 exited the building through the smoking area doors.

On 1/9/25 at 4:18 pm V15, CNA and this surveyor went to the interior and exterior doors that exit the facility to the patio and courtyard smoking area, at the back of the building, north side of the building. The first, interior door does not alarm. The exterior door has a horizontal push bar lever across the center of the door. V15 directed the surveyor to push the bar for a few seconds and it will open. The door did not open. There is a green button to the left of the door. When pushed, the

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door opens and the alarm sounds. V1 was just inside the interior door and responded to the alarm. V15 stated, "They must have already fixed it. This door alarm has not functioned properly for a long time." Once V15, CNA and this surveyor were out on a smoking patio, at the back of the south building, there were two gates. One single-wide gate was to the left, down a sidewalk off the patio approximately 50 feet. A double-wide second gate was straight ahead off the patio, approximately 50 feet. V15 stated the single-wide gate was likely not the gate R1 used, because it opens inward and would be difficult to maneuver R1's wheelchair. V15, CNA and this surveyor walked the approximately 50 feet forward to a double-wide gate, which opens outward. The patio gate has an emergency exit required pushing the button and holding it. No alarm sounded. Together V15 and this surveyor walked approximately 150 feet around the fenced patio to winding sidewalk. The sidewalk sloped downward past two wings of the facility building, as we headed towards the front of the building on the south side. V15, CNA stopped at the edge of the building outside the therapy room. V15, CNA stated, "This is where (R1's) left his wheelchair that night." V15 stated, "In order for (R1) to get to (Street Name) Avenue he would have had to walk from his wheelchair across all this grass and head north again to where I found him." V15, CNA and this surveyor walked down a 50-foot uneven hill, from the sidewalk where R1's wheelchair had been found. At the base of the uneven hill, we continued to walk through the grass another approximately 150 feet straight towards (Street Name) Avenue. The ground was rough with divots throughout. V15, CNA and this surveyor were approximately 10 feet from the street. There were approximately over one hundred, extra-large scattered rocks stacked

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haphazardly from the ground. The large rocks extended up an eight-foot steep incline. At the ground level the extra-large rocks spanned six feet wide at the base and extended upward to a three-foot-wide easement at the street. V15, CNA stated each rock weighed approximately 20 or 25 pounds. The street curb, on each side of the three-foot-wide easement, was eight inches tall. As this surveyor and V15, CNA decided we could not safely balance ourselves on the rocks, we turned to walk in the uneven grass, at the bottom of the eight-foot steep incline. V15 stated, "(R1) may have climbed the rocks, but most likely walked in the grass. He (R1) had a very unstable gait. That is why he used a wheelchair. He had a couple falls in the facility from trying to stand up from his wheelchair. He was not safe to walk on his own. I can't imagine how (R1) was able to walk this area. You (surveyor) and I (V15, CNA) are having a hard time maintaining our balance." As we continued to walk, this surveyor and V15, CNA had on coats. V15 stated, "It was about this cold when I found (R1) (Confirmed on Accu-Weather website, temperature was 23 degrees Fahrenheit, at this time). There was some wind, but no snow." As we continued to walk on the uneven grass next to the steep incline, which was running parallel to the street, the incline gradually level out with the street eight inch curb. We walked past both the North and South facility buildings. We walked across one parking lot entrance road to the facility. The parking lot entrance to the North building junction with the street was crowded with a steady flow of vehicles. The speed limit posted was 35 miles per hour. V15 stated this steady flow of traffic is the normal for rush hour traffic on the and is about the same time R1 would have been out walking in the traffic. After crossing the parking lot entrance, there was a grassy area approximately

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200 feet, next to an apartment complex. Before reaching the apartment parking lot entrance road off the street, there was an approximately 15 feet by 20 feet concrete slab in the grassy area. There was an electrical site warning sign. There were four steel electrical utility transformer boxes on the concrete slab. One of the electrical utility transformer boxes was four foot wide by approximately eight foot long and eight-foot tall. The other three steel electrical utility transformer boxes were approximately three foot tall, by three foot wide and two foot long. The electrical boxes had multiple access doors with pad lock. At the opposite end of the same 200-foot grassy area there was a gas line warning sign. The gas line warning sign was outside of four concrete, two and a half feet tall pillars. The four pillars sat in a square pattern approximately eight feet apart. Inside the four concrete pillars there were multiple metal gas pipes. The gas pipes varied in sizes of approximately two- and three-inch diameters. The metal pipes looked like a play structure for children. The metal gas pipes crossed each other in jungle gym fashion at different heights. The metal gas pipes structure stood approximately eight feet high at its tallest. The gas pipe structure was approximately six feet wide and four feet long at the base. The metal pipes had locks on several of the bar junctions. V15 pointed to the area V15 found R1 on the. R1 was found across the grassy area from the gas pipe structure, in front of the drive to the apartment complex parking lane entrance, in the middle of the north bound lane.

This surveyor measured the mileage by car. R1 traveled on foot on 1/1/25. The distance one way by car, from the facility to where R1 was found, measured four tenths of a mile. This does not include the facility sidewalk distances from the

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back of the south building to the front of the south building, where R1 had left his wheelchair.

The National Oceanic and Atmospheric Administration (NOAH) website documents on 01/01/25 at 4:35 pm, in this city it was 30 degrees Fahrenheit with 10 mile per hour winds, equal to real feel temperature on the skin of 21 degrees Fahrenheit.

On 1/15/25 at 7:20 am V7, Medical Director stated he was informed of several of R1's elopements. None of R1's elopements or attempts reported to V7 by the facility included (R1) that exited the building and was walking down street unassisted. V7 stated V7 did not know R1 was off the facility grounds. V7, stated R1 has Dementia, has been sent to the emergency room post-falls because he is on a blood thinner and had hit his head. V7 stated is his standard protocol to have a resident on blood thinners evaluated at the hospital post unwitnessed falls and witnessed to have hit their head during a fall. V7 stated, "I had not heard a door alarm malfunctioned either. Alarms in the ER (Emergency Room) go off all the time. I even had a patient go hypoxic. No one initially responded to the alarm. It is the same in nursing homes. I think the staff are immune to the sounds of the alarms. They hear them often. (R1) should have been closely supervised to prevent this from happening. His (R1's) Dementia alone put him at risk of elopement. Having had falls, the short time he was in the facility, also put him at risk serious of injury. To hear he was out walking in the street, in cold temperatures, adds to the potential for serious harm. Knowing he had not been assessed by the nurse when he returned to the facility, is even more concerning. A full assessment should have been completed

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immediately, to have gotten a full picture of any harm after the incident. Adequate supervision may have changed all. Yes, he was at great risk of serious injury."

On 1/22/25 at 1:30 pm V38, CNA stated no one had seen (R1) for about an hour. V38 stated V8, Registered Nurse asked everyone night after the facility got a call that R1 was outside the facility.

R1's Care Plan dated 12/31/24 does not document an elopement care area until 01/01/25. R1's care Plan documents the following: "(R1) is an elopement risk/wanderer related to restlessness and agitation. (R1) cut off his (departure alert) bracelet. Date Initiated: 01/01/2025.
He will not leave facility unattended through the review date. Date Initiated: 01/01/2025.
His safety will be maintained through the review date. Date Initiated: 01/01/2025.
Assess for fall risk Date Initiated: 01/01/2025, Enhanced supervision: 1:1 (one on one) within line of sight." "Date Initiated: 01/01/2025 (Departure Alert Device) in place on left ankle. Monitor device is functioning properly, daily." (A)