STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001275	A. BUILDING: _____ B. WING _____	C 04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHLAND NURSING & REHAB	900 EAST SCOTT STREET OLNEY, IL 62450

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation: 2553268/IL190148	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)6) 300.2900d)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 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental	S9999		

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S9999	Continued From page 1	S9999		

and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

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 300.2900 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001275	A. BUILDING: _____ B. WING _____	C 04/21/2025

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S9999	Continued From page 2	S9999		

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 regulations were not met as evidenced by:

Based on interview, observation, and record review, the facility failed to prevent a cognitively impaired ambulatory resident (R1) from exiting the facility unwitnessed and without staff supervision for 1 of 3 residents reviewed for elopement in the sample of 3. This failure resulted in R1, unknown to staff, exiting the facility and walking approximately one block away, falling and sustaining a skin tear over his left temporal region and scattered abrasions over both hands, wrists, and elbows, and then entering a private citizens unlocked vehicle. R1 was treated at the local ER (Emergency Room) for the skin tears and released later that evening.

R1's Face Sheet documented an Admission Date of 3/20/24 and listed Diagnoses including Alzhiemer's Disease and Hypertensive Heart Disease with Heart Failure. R1's Minimum Data Set (MDS) dated 2/5/25 documented that R1 is severely cognitively impaired, wanders, and exhibits behaviors not directed toward others. The same MDS documents that R1 has no impairments in upper or lower body range of motion and requires partial to moderate assistance for walking.

R1's current Care Plan documented a problem area, "Problem start date: 3/20/2024. Resident is at risk for injuries due to exit seeking behaviors. Attempts to exit the building unattended. ELOPEMENT RISK. Approach includes:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001275	A. BUILDING: _____ B. WING _____	C 04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHLAND NURSING & REHAB	900 EAST SCOTT STREET OLNEY, IL 62450

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S9999	Continued From page 3	S9999		

Re-direct as needed/cues; Notify all staff of residents tendency to seek exits; Diversional activities as tolerated; Check residents whereabouts; all with a start date of 3/20/25. Staff to Initiate 30-minute checks, with start date of 4/13/25.

R1's Elopement Evaluation date 4/1/25 documents R1 is cognitively impaired, poor decision-making skills, and/or pertinent diagnosis (Example, dementia, Organic Brain Syndrome, Alzheimer's, delusions, hallucinations, anxiety disorder, depression, manic depression, and schizophrenia). R1's evaluation documents R1 has a history or wandering (into unsafe area), makes statements that they are leaving and displays behavior(s) that may indicate an attempt to leave, body language etc., indicating an elopement may be forthcoming. R1's evaluation documents resident is at risk for elopement, elopement care plan initiated.

A Power of Attorney (POA) Health Care form dated 3/22/24 listed V11 as R1's POA.

A Police Report dated 4/12/25 at 6:18pm documented, in part, "On 4/12/25, I, (V6, Police Officer) was off-duty, when I viewed an older male sitting in the drivers seat of a Chevrolet SUV in the (name of street located 0.2 miles away from the facility) with what appeared to be blood coming from the left upper head area. As I went around the block to come back to the male subject, I called (local city) dispatch on what I viewed and kept them on the phone while I made contact with the male in the vehicle. Before approaching the vehicle, I gave the Illinois registration information to dispatch. Once at the vehicle, the male opened the drivers door, and I viewed scrapes on the palm of his right hand,

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	IL6001275	A. BUILDING: _____ B. WING _____	C 04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 4	S9999		

skin tears that were open and bleeding, and a laceration on the outer left eyebrow area. I requested an ambulance come and check on the male, with dispatch toning out an ambulance to my location. At this time I hung up with dispatch and stayed with the male. While speaking with the male, I learned his name was (R1) and that he had fallen down in front of his vehicle. (R1) advised that he was just sitting in his car for a minute, but he was ready to go now. I viewed (R1) not to be responding correctly, and he did not seem to know where he was at. When I asked (R1) what his address was, he could not tell me and said that 'he lived on that street over there.' I asked (R1) why he was out of his vehicle and how he fell down, he advised 'that he was working on a house and was going home now.' At this time (R1) began reaching for the ignition, but I got his attention back to me advising him that I wanted him to get checked out by the medics before he goes home. (R1) then advised that this was ok, and began thanking me for stopping and helping him. I was then able to reach across the steering column and feel for ignition keys, but they were not there. At this time (R1) told me that they were probably out in the road where he fell, then pointing to the (name of two streets) intersection. At this time (name of responding Officer) was arriving on scene, as well as (name of local ambulance). I advised Medic (name of medic) on the injuries to (R1) and how he didn't know where he was, then recommending he get transported to (name of local hospital). I then went and checked the intersection (R1) pointed to to (sic) see if there were keys out there. No keys were found in the road, at the intersection, or around the vehicle that (R1) was found in. ... I then decided to contact (Name of Long Term Care Facility), being approx a block away and asked to speak to a supervisor. Once a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001275	A. BUILDING: _____ B. WING _____	C 04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHLAND NURSING & REHAB	900 EAST SCOTT STREET OLNEY, IL 62450

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S9999	Continued From page 5	S9999		

supervisor got on the phone, I advised them who I was and asked if they knew a (R1). The supervisor advised that (R1) is a resident in their Alzheimer's wing. I advised that supervisor that (R1) is currently a block away from their facility, ... being loaded up in an ambulance. I was then told that they would have someone there shortly. Approx 10 minutes later, two staff members arrived at my location and advised that they do not work on the wing where (R1) resides, but actually work on the behavioral wing, but were familiar with (R1). Both looked into the open rear door and advised that the male was in fact (R1). At this time one of the staff members asked who had found (R1), and I advised that I had. I explained to them who I was and who I worked for and that I would be making a report on the matter once I am back on duty. They understood and advised me that they would have their boss contact me on Monday (4/14/25). At this time that ambulance transported (R1) to the hospital to address his injuries, and I left the scene along with everyone else ...On 4/14/25, ... I then called (name of Long Term Care Facility) and spoke (to) Administrator (V1). I advised (V1) of who I was and who I work with, and how I was actually on scene this weekend when (R1) was found. (V1) advised that from what they have put together, (R1) was there for dinner and then left and was gone for approx an hour. I asked if their doors have alarms on them and he advised that they do and they are all operating and in working order. (V1) stated that there was a screen off from one of the windows on the front of the building and believe him to have exited out of this window ..."

Emergency Department Provider Notes dated 4/12/25 at 7:39pm documented, "73 year old male who presents to the emergency department for evaluation of a ground level fall. Reportedly

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 6	S9999		

the patient lives in the Dementia Care Unit at a local skilled nursing facility and escaped (from) the unit. He reportedly was running, tripped and fell on the street. Emergency Management System was called and the patient brought into ER (Emergency Room) for evaluation. Skin: Skin tear over left temporal region. Scattered abrasions over hands, wrists, and elbows bilaterally. No lacerations. The patients labs, EKG (Electrocardiogram) and imaging were reviewed and reveal no significant findings as read by the Radiologist. We will discharge him back to his skilled nursing facility."

Nursing Progress Notes documented the following:

4/11/25 at 11:05am: "(R1) is exit seeking this am (morning). He is going to the front door and then is redirected and then the backdoor. When I asked what he was doing he stated, "I am trying to get home." I showed him his room and where he stays. He then said "Bulls**t", and walked off. He requested a ride home from me. I declined and told him I did not drive. He walked away."
4/11/25 at 1:18pm: "Resident continues to try to go out the doors and wanting someone to let him out. This writer was going into the medication room to get a few supplies and resident stated, "Give me the keys." Politely said that is not possible. Resident said, "Let me try the keys to get out." Politely again stated no that the keys are not used for that. Resident still wanted the keys but he did not ask again. Resident is currently in his room watching TV."
4/12/25 at 4:30pm: "Resident has been slapping the tables, laughing out at random times, and trying to leave out the side doors. He is difficult to redirect and states he is trying to get to his car. I redirected resident to common area and provided

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	IL6001275	A. BUILDING: _____ B. WING _____	C 04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHLAND NURSING & REHAB	900 EAST SCOTT STREET OLNEY, IL 62450

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 7	S9999		

him with vanilla pudding. Resident has been making sexual comments to other female residents and telling them he "thinks they look real good" and puckering his lips. Resident redirected to disengage conversation."
4/12/25 at 5:00pm: "Resident continues trying to exit out the side door, it took this writer and CNA (Certified Nursing Assistant) to redirect resident from the door. Resident stated to me "Hey, you look good" and leaned in for a kiss. I politely declined and redirected resident to a chair near the nurse's station. Resident began yelling out and laughing. I asked resident to please stop yelling as this is upsetting the other residents."
4/12/25 at 8:57pm: "Call received at approximately 1830 (6:30pm) from off duty police officer identified as (V6). States he has a gentleman who says his name is (R1). This nurse has advised there is a resident by that name. (V6) is advised this nurse will come to sight (sic) and identify resident. On arrival at location as directed by (V6). Individual is identified as (R1). Ambulance has arrived on scene prior to this nurse and (R1) is on gurney in sitting position with safety buckles on. Calm demeanor. Note head laceration left scalp et (and) minor abrasions on left f/a (forearm). Ambulance has advised will transport to (name of local hospital) for evaluation due to possible head injury. Reported to (V2, Director of Nurses) et have given report to (V1), Facility Administrator. Call received for report from (name of ER Nurse). Resident stable w (with) all x-rays negative ... Resident has stated he was looking for someone when he was walking and he fell in the gravel somewhere. (V2) notified for update."
4/12/25 at 9:34am: "Report received from (V3, Registered Nurse). Resident returning to facility from (name of local hospital). VS (Vital signs) stable. Awaiting arrival back to facility."

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S9999	Continued From page 8	S9999		

4/12/25 at 11:04pm: "Resident up walking in hall. Redirected to bedroom. Resident assisted to bathroom. He states "I'm not tired, I want a snack." I responded politely that he just ate a snack and should try to get some rest. Resident agreed and was assisted back to bed, shoes removed, and lying comfortably in bed. A/O x1. (alert only to self) Speech clear. Answers questions appropriately."
4/13/25 at 12:00am: "Resident up ambulating in halls and common area. I observed him in the common area refrigerator; redirected resident to area next to nurse's station. Resident began asking for another snack; redirected patient back to room. Resident ambulated back to nurse's station complaining of a headache, he states his head pain is "bad." I gave resident Tramadol 50mg (milligrams)...for head pain. Resident then ambulated back to refrigerator and opened it and tried to grab an apple. I shut the door and discussed he cannot have a whole apple and redirected resident back to nurse's station. CNA helped resident back to bed and resident is lying comfortably in bed."

A Neurological Observations Form documented that R1 received neurological checks, all of which were within normal limits, as follows:
4/12/25: Every 15 minutes from 10pm to 11pm.
4/12/25: Every 30 minutes from 11:30pm to 12am.
4/13/25: Every hour from 1am to 3am.
4/13/25: Every four hours from 7am to 11am.

A 30 Minute Checks Sheet documented that R1's thirty-minute checks were initiated on 4/13/25 at 11:30am.

An Event Report-Safety Events-Elopement dated 4/12/25 stated," Event date: 4/12/25 at 6:30pm.

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S9999	Continued From page 9	S9999		

Where and when was resident found? (Name of street that runs behind the facility.) Did resident sustain any injury during the elopement period? Left scalp laceration and left forearm skin tear. Mental status, describe if necessary: As reported to this nurse, resident has participated in negative behavior throughout the day, opening doors, banging on furniture, agitating staff and other residents, loud yelling and exaggerated loud laughing. Interventions: As reported to this nurse, staff unable to redirect throughout shift, behaviors have escalated with louder yelling, looking for his keys to his car and motorcycle. Anger expressed over diet. Evaluation: Elopement Care Plan updated and door handle changed."

A Daily Assignment Sheet dated 4/12/25 documented one nurse and 2 CNA's (V7 and V8) working on the Dementia Care Unit on the 7am to 7pm shift.

An IDPH (Illinois Department of Public Health) final Investigation dated 4/16/25 documented, "This is a Final Investigation regarding the report of a resident elopement on 4/12/25. (R1) a 73 year old male with a diagnosis of Unspecified Dementia was located at the corner of (name of intersection) at the back side of the facility by an off-duty police officer at 6:35pm. (R1) was seen in the dining room of the (name of Dementia Care Unit) at 6:09pm by (V4, Licensed Practical Nurse) and at 6:15 by the CNA on duty. From investigations, (R1) had mentioned that day that he wanted to leave and find his vehicle. Redirection was given to (R1) according to Care Plan and behavior had stopped. (R1) opened door to front office door between 6:15 last time and 6:36 time phone call made to facility by off-duty police and climbed out of the window. The front office on that unit was unlocked and the

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S9999	Continued From page 10	S9999		

screen was out of the open window. (R1) was sent to (name of local hospital) for evaluation. (R1) had a Power of Attorney, Medical Doctor, and police notified. Resident Care Plan updated upon return to include 30 minute checks. Resident remains in facility with no other incident."

On 4/15/25 at 9:27am, V6 stated he was off duty and headed home when he observed an elderly man looking confused and with a bloodied head, sitting in a vehicle parked in front of a residence. V6 stated the man's foot was on the brake but there were no keys in the ignition. V6 stated the man was unable to answer most questions and it was very obvious he was cognitively impaired. V6 stated the man had skin tears on both arms, blood on his face from a laceration over his left eye, and abrasions to his right hand.. When asked about the injuries, he told V6 he fell. He stated to V6 he had been working on a house nearby and he was headed home. When asked where he lived he couldn't answer with an address but pointed and said, "over there." V6 called EMS, and when they responded, one of the Paramedics recognized the man as R1, whom he had previously transported to the hospital. V6 stated he phoned the facility and asked for a supervisor, who confirmed R1 was a resident. V6 stated then 2 staff members responded to the scene and positively identified R1. V6 stated when he spoke to V1 on 4/14/25, V1 stated they had determined that R1 pushed out the screen of a window to elope.

On 4/15/25 at 10:15am, V1 stated there is no video surveillance anywhere in the facility.

On 4/15/25 at 11:35am, V4, Licensed Practical Nurse (LPN) stated she worked on the facility's

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S9999	Continued From page 11	S9999		

Dementia Care Unit on 4/12/25 from 2pm to 10pm. V4 stated she had been told in report that R1 had been having increased behaviors. V4 stated from 2pm on, R1 displayed behaviors of verbal aggression, exit seeking, yelling for his keys, car, and motorcycle, yelling at and mocking other residents, and doing laps around the unit, pushing the exit doors and activating the alarms. V4 stated she had to block R1's attempts to elope by getting between him and the exits several times. V4 stated redirection with snacks, drinks, and diversion did not work at all. V4 stated she was working with 2 CNA staff and there was a lot to do with 25 residents on the unit, most of whom have behaviors, are incontinent, and require maximal assistance with ADL's (Activities of Daily Living). V4 stated after supper, at about 6:00pm, R1 was in the dining room and she gave him his scheduled medications. V4 stated she then had been sitting at the nurses station within eyesight of R1, and the 2 CNAs were doing a mechanical lift on another resident down the hall. V4 stated she left the nurses station to assist a resident and, "The next thing she knew, V3, Registered Nurse, was telling her she needed to do a head count, because the police had found (R1) outside the facility." V4 stated she was surprised R1 eloped as all the exits are alarmed. V4 stated it is her understanding that apparently activity staff left an unlocked door to a small office next to the front exit, and when she and other staff checked the unit, they noticed the window in the office was open and the screen was out and laying on the ground. V4 stated she believes R1 is physically capable of climbing out a window, and it probably took R1 less than a minute to get out. V4 stated she did not have a key to that office, doesn't know who does, and has never tried to open it. V4 stated her shift ended at 10pm, which was approximately the time R1 returned from ER. V4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001275	A. BUILDING: _____ B. WING _____	C 04/21/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 12	S9999		

stated she stayed with R1 until he fell asleep at about 2am because upon his return he continued to have exit seeking behavior. V4 stated she contacted V11 (R1's POA) when R1 returned from ER and informed her R1 had gotten out of the facility, had fallen, was treated at the ER for minor injuries and had returned to the facility. V4 stated after the elopement, all residents at risk for elopement on that unit, which is the majority of them, are now on every 30-minute checks to be documented in the Elopement Binder. V4 stated if the office door had been locked, and/or if they had had another CNA or perhaps a Unit Aid, they could have provided increased supervision for R1 and he would not have eloped.

On 4/15/25 at 12:10pm, V7, CNA, stated on 4/12/25 she worked 7am to 7pm on the Dementia Care Unit. V7 stated all shift, R1 was exit seeking, saying sexual things to and trying to grab staff, and asking for his motorcycle saying he was, "Getting out of here." The off going shift said he had been displaying these behaviors on their shift also. V7 stated for redirection, she tried snacks, talking to R1 one to one, frequent toileting, his favorite TV shows, and playing music for him, but nothing worked. V7 stated R1 displays these behaviors often, and they fluctuate from day to day. V7 stated for the past couple of weeks, his behaviors have been worse. V7 stated on 4/12/25 she recalled seeing R1 after dinner sitting in the dining room at about 5:30pm. V7 stated at some point after 6pm, she heard other staff talking about R1 having eloped. V7 stated when it was discovered R1 eloped, she checked the unit and it was discovered that a small office used for storage had the door unlocked, the window was open and the screen had been pushed out. V7 stated she assumes R1 climbed out the window. V7 stated looking back, when R1

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	IL6001275	A. BUILDING: _____ B. WING _____	C 04/21/2025

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S9999	Continued From page 13	S9999		

pushed on the exit doors on the north and south sides of the building, the alarms were working. V7 stated she does however think R1 has figured out that if you push on the alarmed doors they will open after 15 seconds, but stated they did not hear any door alarms going off when he was out of staffs sight. V7 stated the following day when she came to work, there was an elopement book that all elopement risk residents are to be charted on every 30 minutes. V7 stated having more staff could have prevented R1's elopement, even if it was a Unit Aid or an Activity Aid. V7 stated she feels R1's behaviors are aggravated by boredom. V7 stated multiple staff have told administration they need more help on the unit but are told the Corporation who owns the facility says they are not needed.

On 4/15/25 at 11:25am, 4/16/25 at 8:45am, and 4/19/25 at 8:30am messages were left on V8, CNA ' s voice mail, but the Surveyors calls were not returned.

On 4/15/25 at 2:00pm, R1 was ambulating independently around the Dementia Care Unit, alert only to himself. When asked about the elopement, R1 said he did not remember.

On 4/15/25 at 2:37pm, the shower room on the Dementia Care Unit's north hall was observed to have an unlocked door, and a double window, the right side of which was unlocked, with no screen and no devices to prevent the window to be raised to within approximately 4 inches of the full height. V5, Maintenance Director, who was present, stated R1 could have eloped from that window, but it egresses a courtyard with a locked gate, and no evidence had been found that the gate was left unlocked.

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S9999	Continued From page 14	S9999		

On 4/15/25 at 2:39pm, the alarmed glass double door exit on the north hall, which has a keypad, was checked by the Surveyor, and it was noted that 15 seconds of pressure on both doors did not activate the alarm, but the doors could be pushed open after 15 seconds. The Surveyor called over V5, who was standing at the end of the hallway, and V5 pushed on the doors and confirmed the alarm was not working but the doors were automatically opening. V5 was also able to open the doors using the keypad. V5 stated he was not sure why alarms to the exit door were not working properly, and that he checks all the exits once a week, and it was in working order last time he checked it. V5 could not recall what date he had last checked the door. When the doors opened, a residential area with an intersection of two streets was observed, which V5 stated that was the area where the police had found R1. V5 stated he would fix the door as soon as possible. V5 stated it was possible R1 could have eloped from that exit if the alarm was not working.

On 4/15/25 at 3:10pm, V1 was notified that the Surveyor had observed the above referenced issues with the Dementia Care Unit north exit door self-releasing but not alarming. V1 stated he would be consulting with V5 about it.

On 4/16/25 at 11:05am, V1 stated on 4/12/25 at around 6:45pm, he was notified by V3 that R1 had been found by police less than a block away from the property. V1 stated he was told R1 had a laceration to the head and was being sent to ER. V1 stated he instructed staff to write down their statement of events and for V7 to inspect the building to see how R1 eloped. V1 stated a "Complete sweep of the property," showed the door to the small office by the front entrance was unlocked, the window was open, and the screen

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S9999	Continued From page 15	S9999		

was out. V1 stated on 4/12/25 at 1pm, V1 was at the facility for an Easter egg hunt, and he observed that the window where R1 allegedly eloped as being closed with the screen in it. V1 stated activity staff had been accessing the small office where some of the supplies were kept for the Easter egg hunt. and could have left the door unlocked. V1 stated he instructed V5 to put a self-locking handle on the door of that office, which was done on 4/14/25. V1 stated staff are doing every 30-minute checks on all residents at risk for elopement on the Dementia Care Unit. V1 stated V9, Social Services Director, came to the facility on 4/13/25 and began reeducating staff on checking exits and windows and doing visual checks on elopement risk residents every 30 minutes.

On 4/16/25 at 8:15am, the north hall double door exit on the Dementia Care Unit was checked by the Surveyor with V5. The alarm was still not working, but the doors did not release when pressure was applied. The keypad was working. V5 stated he, "Messed with," the door the previous day but could not get the alarm to work. V5 stated he called the company that services the alarm doors, but they could not come out until the following week.

On 4/17/25 at 2:25pm, V2, Director of Nurses, stated staff chart behaviors that are unusual for the resident on an Event Report document. V2 stated staff do not do behavior tracking, but chart behaviors that are usual for the resident in the Nurses Notes.

On 04/18/2025 at 11:27 A.M. V1 stated that R1 upon his return to the facility was on neurological checks, and that after the neurological checks were completed the facility started the 30-minute

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S9999	Continued From page 16	S9999		

checks.

On 4/18/2025 at 1:40 P.M. R1 was observed standing at the end of the hallway on the Dementia Care Unit pushing on the north exit door, and then wandering into a resident room a few seconds later.

On 04/18/2025 at 1:43 P.M. R1 was observed standing at the exit which adjoins the Behavior Unit, pushing the buttons on the keypad.

On 4/19/25 at 8:40am, V11 (R1's POA) stated on 4/12/25 she was called by a facility nurse, name unknown, who told her "(R1) had got outside and he fell, he had just come back from ER, but he was ok." V11 stated she was extremely upset about staff not calling her when they first became aware of the elopement, nor did they provide the full details of the event. V11 stated she has been questioning the facility's ability to adequately supervise R1 and she has been looking for an alternative placement. V11 stated, "It is way more likely he got out an exit than climbing out a window, though it is possible."

On 4/19/25 at 11:40am, V10, Physician/Medical Director, stated he was on 4/12/25 of the elopement. V10 stated he has concerns that the facility may be understaffed, but stated he has no control over making decisions about staffing patterns.

The facility's Door Alarm/System Check Logs for March and April 2025 documented the alarmed exit doors for both of the facility's buildings were being checked once weekly. The April Log documented the alarms were checked on 4/4/25 and in working order, were not checked when due on 4/11/25, but were again checked on 4/14/25

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S9999	Continued From page 17 after the elopement occurred. An Elopement Prevention Policy dated 5/16/24 stated, "It is the policy of (the facility) to provide a safe and secure environment for all residents. To ensure this process, the staff will assess all residents for the potential for elopement. Determination of risk will be assigned for each individual resident and interventions for prevention be established in the plan of care to minimize the risk for elopement. 11. Door alarms are checked daily by maintenance for function." On 4/19/25 at 3:00pm, when asked why V5 had not been checking the alarmed doors daily per facility policy, V1 stated he was unaware that this was the policy. A Safety and Supervision of Residents Policy dated 4/16/25 documented, " 9. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual residents assessed needs and identified hazards in the environment. 10. The type and frequency of resident supervision may vary among residents and over time for the same resident. For example, resident supervision may need to be increased when there are temporary hazards or if there is a change in the resident's condition." (A)	S9999		