DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Suite 200, Cambridge Bldg
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Millcroft Living Nursing Home

DATE SURVEY COMPLETED: August 28, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced Complaint and Extended was conducted at this facility from August 23, 2024 through August 28, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was eighty-one (81). The sample totaled five residents.	Completion date 10/7/24
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed August 28, 2024: cross refer: F609, F610, F689, F944 and F949.	

Provider's Signature Kristopher Brown Title Executive Director Date 9/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085021	A. BUILDING _____ B. WING _____	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCROFT LIVING	255 POSSUM PARK ROAD NEWARK, DE 19711

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F 000	INITIAL COMMENTS An unannounced Complaint and Extended was conducted at this facility from August 23, 2024 through August 28, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was eighty-one (81). The sample totaled five residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nursing Assistant; CS - Clinical Specialist; DON - Director of Nursing; ED - Executive Director; EVS - Environmental Services Director; Family Member - FM; FSD - Food Service Director; H - Housekeeper; LPN - Licensed Practice Nurse; RN - Registered Nurse; SLP - Speech Language Pathologist; UC - Unit Clerk; UM - Unit Manager; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 0 to 15. 13-15: Cognitively intact. 8-12: Moderately impaired. 0-7: Severe impairment. EMR - Electronic Medical Record; Elopement - leaving a safe area of the facility without supervision;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/20/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 MAR - Medication Administration Record; MDS (Minimum Data Set) - standardized assessment forms used in nursing homes; Wander -guard - a bracelet that is wired to trigger alarms when near alarmed exit doors.	F 000		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 609		10/7/24

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F 609	Continued From page 2 Based on record review and interview it was determined that for three (R1, R2 and R3) out of three residents reviewed for elopements the facility failed to recognize the elopements as allegation's of neglect. This resulted in the failure to report them to the State Agency. Findings include: The facility policy titled "Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating" last updated, September 2022 indicated,"If resident abuse neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected the suspicion must be reported immediately to the administrator and to other official according to state law. The administrator or the individual making the allegation immediately reports his or her suspicion to the state agency..." 1. 7/11/24 - R3 eloped from the facility. 2. 8/16/24 and 8/18/24 - R1 eloped from the facility. 3. 8/17/24 - R2 eloped from the facility. 8/22/24 - Review of the State Agency's Incident Referral Center revealed the facility's last reported elopement was on 11/30/22. During an interview on 8/23/24 at 12:50 PM, E1 (ED) confirmed the facility failed to recognize elopements as suspicions of neglect, resulting in a failure to report them to the State Agency. E1 stated, "From my understanding the resident has to be off facility premises for an elopement to occur" when asked why R1, R2 and R3's elopements were not reported.	F 609	Corrective Action: " R3 continues to reside in the facility while R1 and R2 are no longer residents in the facility. All alleged violations were reported on 8/26/2024 to the state agency. All facility staff were educated on reporting requirements for all alleged violations. Identification of Other Residents: " All Residents have the potential to be affected. A 100% audit of all residents for elopement risk was completed. Those identified as elopement risk had their care plan reviewed and updated to reflect all necessary interventions to help prevent elopement. Residents will be protected by ensuring that staff members are educated on reporting alleged violation involving elopement per facility policy and state requirement. System Changes: " The Root Cause of the concern was a failure to recognize the elopements as allegation of neglects and failure to report them to the state. The facility policy for Wandering and Elopements (rev. 3.2019) and Abuse, Neglect, Exploitation or Misappropriation □ Reporting and Investigating (rev. 9.2022) was reviewed and found to meet professional standards. All facility staff are to be educated on requirements for timely reporting of all allegations of abuse, neglect. exploitation or mistreatment including suspicion of crime. Daily Interdepartmental Team (IDT)	

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F 609	Continued From page 3 During an interview on 8/26/24 at 2:51 PM, E4 (CS) stated, "we thought it was too late to report now" and E3 (ADON) stated the facility will report the incidents "now". 8/27/24 - The facility reported R1, R2, and R3's elopements to the State Agency. Findings were reviewed during the exit conference on 8/28/24 at 1:06 PM with E1 (ED), E2 (DON) and E3 (ADON).	F 609	rounds review and discussion of Residents on the Elopement Risk List as well as elopement attempts and newly identified elopement risks, to include IDT verification of reporting of violation are in place to prevent future reporting violation. The facility system for managing staff development program has been updated to include a monthly review of elopement concerns and compliance with reporting requirements in the monthly Quality Assurance and Performance Improvement (QAPI) committee meeting. If concerns are identified an action plan will be initiated. The Executive Director or designee will complete education for all staff regarding reporting of alleged violations like elopements. The administrator and the nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: " An initial 100% audit of all staff by the Executive Director or designee will be completed to ensure that staff are educated in recognizing and timely reporting of elopement to state agency per facility policy. Then a 100% audit of newly hired staff will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will	

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F 609	Continued From page 4	F 609	be reviewed by the Quality Assurance Team. " A 100% audit of all reports of alleged elopement will be completed by the Executive Director or designee at the time of the report of the alleged elopement to ensure that all alleged elopement is recognized as such and reported timely per facility policy. The results of the audits will be reviewed by the Quality Assurance team.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R3) out of three residents reviewed for elopement the facility failed to thoroughly investigate an allegation of	F 610	Corrective Action: " R3 continues to reside in the facility. Corrective actions have been ensured by the Executive Director and the Director of	10/7/24

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F 610	Continued From page 5 neglect. Findings include: The facility policy titled "Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating" last updated, September 2022 indicated, "All investigations will be thoroughly investigated". 7/11/24 2:40 PM - A progress note in R3's clinical record documented the resident eloped from the facility. 8/23/24 9:15 AM - The Surveyor requested the investigative documents for R3's elopement. 8/23/24 2:12 PM - E2 (DON) confirmed there were no investigative documents for R3's 7/11/24 elopement. Findings were reviewed during the exit conference on 8/28/24 at 1:06 PM with E1 (ED), E2 (DON) and E3 (ADON).	F 610	Nursing. The Administrator and Director of Nursing have completed a review of the incident with Resident R3 and the failure to adequately investigate, to avoid a recurrence. The incident regarding Resident R3 has been reviewed, and a Care Plan review has been completed for Resident R3 to ensure that no Care Plan changes are needed considering the incident. All Residents have been reassessed for elopement risk, including Resident R3, to help prevent elopement in the future. The responsible party for Resident R3 has been notified to provide a summary of the review and investigation of the incident. Identification of Other Residents: " All Residents have the potential to be affected. A 100% audit of nurses notes for a 30-day lookback period for all current residents to identify any incident requiring reporting and investigation to ensure that investigation was done has been completed. No new concerns regarding investigation of alleged violations were identified because of this audit. System Changes: " The Root Cause of the concern was a failure by the facility to thoroughly investigate an allegation of neglect. The facility policy for Abuse, Neglect, Exploitation or Misappropriation □ Reporting and Investigating (rev. 9.2022) was reviewed and found to meet professional standards. The facility system for managing alleged neglect investigating has been updated to include	

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F 610	Continued From page 6	F 610	a daily review of compliance in the daily Monday to Friday Interdepartmental team (IDT) Clinical Meeting to ensure adequate follow-up and investigation of all concerns. The facility system for Administrator and Director of Nursing notification of incidents has been updated to include education of the nursing staff on the protocols for notification and to notify the Administrator or Director of Nursing for any incident involving an alleged neglect, as well as any situation in which a resident is at high risk for elopement, and any other reportable event (abuse, neglect, misappropriation, etc.); nursing education includes the need to notify the Administrator and/or Director of Nursing immediately regarding alleged neglect. The facility system for QAPI has been updated to include a monthly review of compliance in the monthly Quality Assurance and Performance Improvement (QAPI) committee meeting. The administrator and the nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: " A neglect Allegation Investigation audit to ensure compliance with investigation requirements will be completed by the Director of Nursing or designee; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance	

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F 610	Continued From page 7	F 610	is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other facility documentation it was determined that for three (R1, R2 and R3) out of three residents reviewed for wandering and elopement the facility failed to provide adequate supervision to prevent elopements. R1 eloped on two occasions 8/16/24 and 8/18/24. On 8/16/24, R1 was seen in the parking lot. On 8/18/24, R1 was seen outside of the building, near the fire lane of the facility turn-in and a busy roadway. Additionally, R2 eloped from the facility on 8/17/24 and was found outside of the building at the edge of the curb on the rounded driveway. On 7/11/24, R3 was seen exiting the facility unattended by a facility visitor who immediately reported R3's elopement to staff. The facility was made aware on 8/23/27 at 4:47 PM of immediate jeopardy. All three residents were at risk for serious adverse outcome. The immediate	F 689	Corrective Action: " R1 and R2 are no longer residents in the facility while R3 continue to reside in the facility as of the time of writing this plan of correction. Corrective actions have been ensured by the Administrator and the Director of Nursing. Immediate action was taken in response to the identified concerns related to resident safety and supervision. All residents known to be at risk for elopement were checked to ensure that they did not possess scissors or other sharp objects that could potentially be utilized to remove their wander guard. The keypad alarm code for the wander guard was changed. Signage notifying visitors of "High Elopement Risk On Floor. Wander Guard System In Place. Only Nursing Staff to Disarm the	10/7/24

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F 689	Continued From page 8 jeopardy was abated on 8/24/24. Findings include: The facility policy entitled "Wandering and Elopements" indicated, "The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If identified as at risk for wandering, elopement, or other safety issues, the resident care plan will include strategies and intervention to maintain the resident's safety." 1. Review of R3's clinical record revealed: 5/9/24 - R3 was admitted to the facility with a history of multiple diagnoses including dementia and unsteadiness on his feet. 5/9/24 - R3's admission elopement evaluation scored a "3" and assessed that the resident was at risk for wandering. The evaluation assessed that R3 wandered, and the wandering was likely to affect the safety of the resident or others. 5/15/24 - An admission MDS assessment documented R3 as having active diagnoses of anxiety, dementia, and severe cognitive impairment. R3 was assessed as using a walker and able to walk ten feet with moderate partial assistance and supervision. 5/27/24 - R3's care plan for wandering was created with interventions of distract resident from wandering by offering pleasant diversions, structured activities, food conversation, television, books. Staff is aware of elopement risk. 7/11/24 2:40 PM - A progress note in R3's clinical	F 689	Alarm. Make sure that No Residents are behind you before Exiting", was placed on all doors and keypads on the 1st and 2nd floors. The double doors leading into the health center from the kitchen and through to the main exit corridor were closed and a written memorandum was issued to kitchen staff, instructing them to keep doors leading from the kitchen to the health center closed after they go through them. Every shift order in place for wander guard placement and daily function checks for residents with the device. Immediate facility-wide staff education on the elopement prevention policy was completed. Resident R1 had an updated elopement risk assessment and care plan review completed to reevaluate the resident elopement risk and ensure that the care plan included all necessary interventions to help prevent elopement in the future. Resident R2 had an updated elopement risk assessment and care plan review completed to reevaluate the resident elopement risk and ensure that the care plan included all necessary interventions to help prevent elopement in the future. Resident R3 had an updated elopement risk assessment and care plan review completed to reevaluate the resident elopement risk and ensure that the care plan included all necessary interventions to help prevent elopement in the future. Identification of Other Residents: " All Residents have the potential to be affected. A 100% audit of all residents for elopement risk was completed. Those	

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F 689	Continued From page 9 record written by E22 (RN,UM) documented, "Resident was found on outside driveway loop by another resident's family. Resident retrieved and had no apparent injuries and no complaints of pain. Elopement evaluation completed, resident at high risk for elopement. Family contacted and made aware. MD made aware and ordered wander guard. orders placed, wander guard placed on left ankle without incident. Resident to continue to be at nurses station during the day for observation." 7/11/24 - R3's elopement evaluation scored a "6" and assessed that in addition to the prior evaluations assessment, R3 now had a history of elopement, expressed a desire to go home, and that wandering was likely to affect the privacy of others. 7/11/24 - A physician's order was written for R3 to wear a wander-guard and for placement of the wander-guard to be checked every shift. During an interview on 8/26/24 1:14 PM, E22 (RN, UM) confirmed that R3 was found outside the facility on 7/11/24. E22 stated, "[R3] was at an activity and he was upstairs and a residents family member [FM2] said [R3] is outside in the circle. He was last seen in an activity we assume he went out on the elevator alone then outside." E22 confirmed the facility was unaware R3 was outside prior to notification from FM2. During an interview on 8/26/24 at 1:24 PM, FM2 stated, "There was one time mid July a resident [R3] got out. I was outside and [R3] came walking out said he was going home. So I went in and told the first person I saw but by the time we got there someone was already coming in with him. He	F 689	identified as elopement risk had their care plan reviewed and updated to reflect all necessary interventions to help prevent elopement. System Changes: " The Root Cause of the concern was a failure by the facility to provide adequate supervision to prevent elopements. The facility policy for Wandering and Elopements (rev. 3.2019) was reviewed and found to meet professional standards. The facility system for managing elopement prevention has been updated to include daily (Monday to Friday) IDT rounds review and discussion of Residents on the Elopement Risk List as well as elopement attempts and newly identified elopement risks, to include IDT verification of effective interventions are in place and reflected on the care plan in order to help prevent elopement. Each floor is to have an elopement risk binder at the nursing stations for all resident identified to be at risk, and included in the binder is the pictures, wander guard site, mobility status, room number and date of birth. The Binder is to be updated weekly and as needed. All exit keypad codes had their access codes reset, and codes are to be changed every quarter. Elopement risk assessment/evaluation to be completed on admission and with change in condition. The Director of nursing or designee must be notified immediately a resident is identified as at-risk for elopement. The administrator and the nursing management team will provide oversight to ensure ongoing compliance.	

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F 689	Continued From page 10 only had about one minute of freedom." During an interview on 8/27/24 at 11:44 AM, E18 (CNA) who was assigned to R3 on 7/11/24 during the day shift stated, "I don't remember much because I just heard about it, but I didn't see it. I am pretty sure I was with another resident." E18 was unable to recall when she had last seen E18. 2. Review of R1's clinical record revealed: 7/17/24 - R1 was admitted to the facility with multiple diagnoses including unspecified dementia with agitation, anxiety disorder, unspecified psychosis, unsteadiness on the feet and difficulty walking. 7/17/24 - A baseline care plan was created for R1's risk for elopement with the goal that R1 would not elope from the community. Interventions included complete admission elopement evaluation and initiate placement of a wandering device. 7/17/24 - The comprehensive care plan for R1 for risk of wandering/elopement with a goal for safety to be maintained included interventions to complete frequent checks every shift, identify if there is a certain time of day wandering elopements attempts occur and schedule time for regular walks/appropriate activity. There were no updates/revisions to this care plan. 7/17/24 - R1's admission elopement evaluation scored R1 as a "3" and assessed that R1 was at risk for elopement related to a history of attempted elopement while at home, history of elopement or attempted leaving the facility without informing staff and wandering.	F 689	Success Evaluation: " An initial 100% audit of all residents to evaluate elopement risk and needed interventions will be completed; then, an audit of a random sample of 10% of residents for elopement risk intervention (identification of risk, interventions, and care plan) will be completed by the Director of Nursing or Designee to ensure that all elopement interventions are in place per the plan of care; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	

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F 689	Continued From page 11 7/23/24 - An admission MDS assessment documented that R1 had a BIMS score of six indicating severe cognitive impairment. The wandering section of the assessment was left blank, indicating it was incomplete. R1's functional ability was documented as able to walk ten feet with supervision and use of a walker. 8/13/24 - A second elopement evaluation scored R1 as a "6" and assessed that R1 continued as at risk for elopement related to a history of attempted elopement while at home, history of elopement or attempted leaving the facility without informing staff and wandering. Additionally, R1 was assessed as wandering aimlessly or non-goal directed and wandering behavior likely to affect the safety or well-being of R1 and privacy others. 8/13/24 - A physician's order was written for R1 to wear a wander-guard and for placement of the wander-guard to be checked every shift. a. 8/16/24 4:22 PM - A progress note in R1's clinical record written by E14 (RN) documented, "Resident noted to be an elopement risk with wandering behavior. Resident has wander-guard in place. It was proposed to the family to move the resident to the second floor as a safety precaution. Family refused at this time." 8/16/24 - An un-timed statement in the investigation documents written by E22 (RN-UM) documented that R1 was "found in the parking lot by housekeeping and bought back to the floor by two CNA's...". 8/16/24 - An un-timed statement in the	F 689		

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investigation documents written by E16 (CNA) documented, "[E21 (H)] was on her way outside and said someone was outside with a handbag and seemed lost could we see if she was a resident? So, I went outside only to see [R1] by the cars in the parking lot."

8/16/24 - A third elopement evaluation scored R1 as an "8" and assessed that R1 continued as at risk for elopement related to a history of attempted elopement while at home, history of elopement or attempted leaving the facility without informing staff, wandering aimlessly and wandering behavior likely to affect the safe or well-being of R1 and privacy others. Additionally, R1 was assessed as verbally expressing a desire to go home.

8/22/24 - R1's existing wander-guard order was expanded to include checking the function of the wander-guard daily.

During an interview on 8/23/24 at 2:20 PM, E21 (H), stated that on 8/16/24, "Maybe at 2:00 PM or 2:30 PM I was at the time clock to punch out, I heard the alarm and I look out the window and see [R1] outside and went and got [E16 (CNA)]." During the interview E21 accompanied the surveyor to the time clock and confirmed seeing [R1] through the window outside on 8/16/24.

During an interview on 8/26/23 at 2:26 PM, E12 (RN) confirmed that she was assigned to [R1] on 8/16/24 during the time of the elopement. E12 stated, "I was in another patient's room and didn't know [R1] got out."

During an interview on 8/23/24 at 2:28 PM, E18 (CNA) stated that on 8/16/24, "I believe I was

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heading to the kitchen and [E21 (H)] was standing there. [E16 (CNA)] was standing there. Me and [E16] go out there. We didn't notice [R1] left because someone must have disarmed the alarm." E18 then confirmed other incidents of elopement regarding R1 and stated, "I just heard about Sunday (8/18) where she was found across the street but I wasn't here that day."

During an interview on 8/23/24 at 2:32 PM, E22 (RN) stated that on 8/16/24, "I just remember I was off the floor and when I had come back they said she made it out to the cars and a housekeeper found her. We came up with putting her on the second floor and [FM1] said he didn't want to do that because she had a friend on the first floor and I explained it was a safety measure and he refused. We did make signs and we put those on the glass doors and above the key pad." E22 confirmed that the it was unknown how long R1 had been outside of the facility and stated, "I'm not sure how long but it couldn't have been more than five or ten minutes at the most. She had been sitting on the couch." E22 denied that R1 had prior elopements and stated, "[R1] did voice the desire to leave. We saw her walking off the unit but she had not made it beyond that. With difficulty to redirect, we did do a wander-guard." E22 was asked to show the surveyor the sign and when visualizing the Healthcare entrance door key pad there was no sign posted. E22 stated, "Housekeeping must have taken them down." E22 then provided the surveyor with a copy of the signs she created and posted on 8/16/24. The sign indicated the following "HIGH ELOPEMENT RISK ON FIRST FLOOR. ONLY NURSING STAFF TO DISARM THE ALARM! Thank you."

During an interview on 8/23/24 at 2:37 PM, E16

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F 689	Continued From page 14 (CNA) stated, "That day we were getting our last changes done. I can't remember what time it was. I do know that housekeeping leaves around 2:30 so it had to be around that time frame. I was charting and [E7 (H)] ran to the desk and she said I think a resident is out. I got up immediately and darted towards the door. When I went out, I saw it was [R1]. When I ran out to the parking lot two housekeepers was trying to get her to come in." E16 stated that R1 was observed outside in the parking lot "by the spot that says visitor where the doctors park at." b. 8/18/2024 10:40 AM - A progress note in R1's clinical record written by E22 (RN-UM) documented, "Resident wandered out of facility; Charge nurse was made aware by [E10 (AD)] while on break. Resident was encouraged to returned to facility from the front main entrance, Resident had some combative behaviors. Resident returned to first floor unit. ADON and CEO were made aware. Resident's son was called and made aware and notified of patient transfer to second floor unit. Patient was transfer to second floor." 8/18/24 - An un-timed statement in the investigation documents written by E3 (ADON) documented, "[E10 (AD)] notified me Sunday morning that an attempted elopement occurred with [R1]. I notified [E2 (DON)] and [E1 (ED)]. I was informed that resident made it to the edge of the premises, but no one knew whether she left the actual premises." 8/18/24 - R1 was relocated from a room on the first floor to a room on the second floor of the facility.	F 689		

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F 689	Continued From page 15 8/23/24 9:23 AM - During random observation and tour of the facility, two sets of double doors with a service area between them that connected the Healthcare facility and Independently Living facility were observed to be open. The doors remained open throughout the day. During an interview on 8/23/24 at 11:35 AM, FM1, responsible party for R1, confirmed R1's 8/18/24 elopement and stated, "I was under the impression it was during the day on Sunday around ten. My mom has dementia, and she does this sometimes, as her situation has worsened. They have worked with us, taking as much control as they can. They moved her to a more secure floor and put an alarm on her. From what somebody told me, she went for a walk. I think from what I gather, she may have gone past the entry way of [the facility] and off the grounds proper. From what I was told, she wasn't far away, and I don't think she knew she was off the grounds." FM1 stated he was unaware of other elopements at the facility. During an interview on 8/23/24 at 12:21 PM, E10 (AD) confirmed that R1 eloped on Sunday 8/18/24. E10 stated, "I was in the hallway downstairs in the Independent Living and the receptionist [E8] was calling my name and she said she thought there was a Healthcare resident in the parking lot. If you're coming into the facility [R1] was right at the corner with her walker and a gentleman." E10 confirmed the "gentleman" was a person unknown to the facility and referred to him as a "good Samaritan" and reported she obtained his contact information and gave it to E1 (ED). E10 then stated, "Me and one of my staff [E14 RN] escorted [R1] in." E10 stated, I think there is one other episode [of elopement] I'm not	F 689		

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sure. R1 did have her wander-guard on when I bought her back through the door it did go off."

During an interview on 8/23/24 at 12:50 PM, E1 (ED) stated, "I wasn't in the building, so I didn't know anything about the elopement on the sixteenth. On the eighteenth, [E10 (AD)] called me and said a resident was out on the sidewalk and looked confused. She went and got her back. [R1] did have a wander-guard. Depending on the door she goes through, it goes off. I don't know which door she came out of."

During an interview on 8/23/24 at 1:11 PM, E7 (DES) confirmed that the Independent Living main entrance doors do not sound an alarm and do not automatically close or lock when a wander-guard passes through. The last alarmed door triggered by wander-guards is the first set of double doors that lead to the service hallway where the kitchen and employee break room is located that then lead to the Independent Living main hallway to its main entrance door. When a wander-guard passes through the first set of double doors, an alarm sounds until disarmed by a pin number entry on the keypad. The doors do not lock. The doors were observed as open at the time.

During an observation on 8/23/24 at 1:14 PM E7, (DES) demonstrated with the use of a wander-guard that the facility's Healthcare main entrance doors alarm until disabled and lock temporarily when triggered by a wander-guard.

During an observation on 8/23/24 at 1:21 PM, at the Independent Living main entrance, E7 (DES) had triggered the double door wander guard alarm. However, it could not be heard at that

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distance.

During an interview on 8/23/24 at 1:22 PM, E7 (DES) confirmed that the set of two double doors connecting the Healthcare Facility to the Independent Living facility were "typically open during the day."

During an interview on 8/23/24 at 1:29 PM, E8 (receptionist) stated that on 8/18/24, "Another Independent Living resident told me [R1] was in the middle of the street. I called [E10 (AD)], she was the manager on duty, and I got up to see if I could see [R1], but I couldn't see her. I did see someone bring her back towards the building. When the lady, a visitor, told me someone looked like they belong here was in the road. I got up because I couldn't see, but by the time I got up, she was near the flagpole where the cars come in."

During an interview on 8/23/24 at 3:36 PM, E14 (RN) stated that on 8/18/24, "I was the nurse that day. I went on break and while I went on break an employee [E10 (AD)], came and told me that a resident [R1] is outside." E14 confirmed that R1 was seen at the nurse's station before E14 went on break and that it was an estimated twenty minutes later when E14 was notified that R1 had exited the facility. E14 then confirmed that the facility was not aware that R1 had exited the facility unbeknownst to staff.

During an interview on 8/23/24 at 4:03 PM, E3 (ADON) confirmed that during both the 8/16 and 8/18 elopements, staff had no knowledge R1 would be exiting the building.

c. 8/23/24 11:52 AM - A progress note in R1's

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clinical record documented, "Resident was found without her wander-guard on the second floor. 8/23/24 7-3 shift. Small pair of manicure scissors found in her room. Resident cut the strap off herself. New wander-guard placed around the resident's right ankle. Scissors removed from the residents room and placed in the medication room behind the nurses station. Resident's POA [FM1] notified of incident. Resident remains a high elopement risk."

During an interview on 8/23/24 at 4:26 PM, E13 (RN) stated that R1 was "standing in the hall and we noticed she did not have it [wander-guard] on. Her nurse went in the room and saw the strap cut. So we confiscated the scissors. Then [FM1] came in and took them and we searched them and didn't find anymore."

3. Review of R2's clinical record revealed:

8/6/24 - R2 was admitted to the facility with multiple diagnoses including age related physical weakness, unsteadiness of the feet, dementia and cognitive communication deficits.

8/6/24 - R2's admission elopement evaluation scored a "0" which indicated the resident was assessed as not a risk for elopement.

8/12/24 - An admission MDS assessment documented R2 as having a BIMS score of "10" indicating moderate cognitive impairment. R2 did not exhibit wandering behaviors and required moderate partial assistance to walk 10 feet and used both a wheelchair and a walker.

8/17/24 3:19 PM - A progress note in R2's clinical record written by E13 (RN) documented,

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"Resident noted to be elopement risk. Found outside of building on 8/17/23, around 3:00 PM. Resident unharmed. In stable condition. Back in room. Resident's spouse informed and has given consent for a wander-guard."

8/17/24 - An un-timed statement written by E13 (RN) in the investigation documents indicated, "It was nearing 3:00 on 8/17/24 on first floor. The speech therapist wheeled [R2] in through the side door and reported that he found him sitting by the pond outside in his wheelchair. Resident has a baseline as being confused and had already been redirected several times that day. I immediately spoke with the resident's POA and obtained consent for a wander-guard."

An undated/un-timed statement written by E19 (SLP) in the investigation documents indicated, "On 8/17/24 3:00 PM, I was approached by a visitor saying a resident [R2] was outside alone wheeling himself. I went to [R2] and bought him back to the facility and reported to nursing... I found him at the Independent Living side entrance door by the pond."

8/17/24 - R2's second elopement evaluation scored a "6" which indicated the resident was assessed as at risk for elopement.

8/17/24 - A physician's order was written for R2 to have a wander-guard and for staff to check placement and function each shift.

During an interview on 8/23/24 at.11:11 AM, E15 (LPN) was asked if he was aware of any resident elopements in the facility. E15 responded, "Yes, I worked on Sunday, there was an elopement. I can't remember the name of the resident." When

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F 689	Continued From page 20 asked if the elopement was regarding R1, E15 stated, "No, I don't know about the resident. It was a gentleman, [R2]." During an interview on 8/26/24 at 2:03 PM, E13 (RN) confirmed the above written statement. E13 then confirmed the facility was unaware R2 was outside until E19 (SLP) "wheeled him in." R13 was unsure of when or where R2 had last been seen prior to being found outside by E19. During an interview on 8/27/24 at 11:48 AM, E19 (SLP) confirmed the above written statement. E19 then accompanied the surveyor outside where R2 was found by him on 8/17/24. E19 confirmed R2 was found outside near the side entrance of the Independent Living area, at the edge of the turn. Across the fire lane there is a small man made pond and embankment. The facility provided the following corrective measures: During an interview on 8/23/24 at 4:09 PM with E1 (ED), E2 (DON) and E3 (ADON) the surveyor asked what the facility's plan is to prevent further elopements and E3 responded, "For [R1] we had moved her upstairs. We attempted to move her Friday, but they refused. Moving her upstairs is another layer for her safety. In general, we had been communicating and educating the staff that when they hear the alarm to make sure that someone is there to disarm. We have families that like to go in and out it would be better if just the nursing staff only would put in the code." E1 then stated, "I am going put a sign up". E3 then added," if we identify residents at risk on admission if we have a room, we will put them upstairs. We made sure the doors were working,	F 689		

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F 689	Continued From page 21 notified staff and did frequent rounding" E3 confirmed the "frequent rounding was not documented". 8/23/24 4:13 PM - The surveyor requested any recent education provided to staff regarding wandering and elopements. 8/23/24 - 4:30 PM - E3 (ADON) provided the surveyor with education sign in sheet's regarding wandering and elopements dated 8/23/24. 8/23/24 4:31 PM - E1 (ED) Was shown the signs created by E22 (RN) that were to be placed by exit doors. E1 confirmed signs were not posted presently. 8/23/27 4:47 PM - Surveyor reported to E1 (ED), E2 (DON) and E3 (ADON) that an immediate jeopardy in the area of accidents hazards had been identified regarding the facility's failure to provide adequate supervision to prevent elopements. The surveyor asked how the facility would prevent residents from exiting the facility. E1 stated, "Going forward only a nurse is to disarm the code. I will call the company about changing the alarm pin codes as soon as possible." E3 stated, "yes, because the families have the codes." 8/23/24 -4:52 PM - E1 (ED) - Provided the surveyor with a sign to be posted on all exit doors. The sign read, "DO NOT REMOVE SIGN. HIGH ELOPEMENT RISK ON FIRST FLOOR (WANDER GUARD SYSTEM IN PLACE). STOP. Only NURSING STAFF to DISARM the ALARM (Please make sure no residents are behind you before exiting) * If alarm goes off, please notify a nursing staff member to turn off the alarm before	F 689		

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F 689	Continued From page 22 proceeding*." 8/23/24 5:08 PM - E1 (ED) was sent an email with an attached immediate jeopardy template. 8/23/24 5:09 PM - 5:53 PM - Signage was posted on all the entrance/exit doors "Only nursing to disarm alarms. Warning high risk elopement residents in facility". 8/23/24 5:52 PM - 6:21 PM - All exit/entry Door alarm pin code changed. 8/23/24 5:53 PM - Set one of double doors closed with a verbal notice from E1 (ED) to dietary and other staff for the doors to remain closed. 8/23/24 - 6:00 PM - 6:09 PM - All residents with wander-guards belongings inspected for objects to remove wander-guard list provided by E3 (ADON). 8/23/24 6:20 PM - E1 (ED) provided written notice to dietary staff and surveyor to ensure double doors between the Healthcare center and Independent Living area remain closed. 8/23/24 7:13 PM - E1 (ED) provided a written removal plan to the State Agency via email. 8/26/24 - E1 provided additional sign in sheets for education regarding wandering, closing of the double doors, disabling of alarms and elopement dated 8/24/24. 8/26/24 - Staff interviews with E5 (FSD), E13 (RN), E23 (LPN), E24 (UC), E25 (LPN), E26 (H), E17 (CNA) confirmed the recent education.	F 689		

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	085021	A. BUILDING _____ B. WING _____	C 08/28/2024

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F 689	Continued From page 23 The facility completed the abatement on 8/24/24 at 2:30 PM. Findings were reviewed during the exit conference on 8/28/24 at 1:06 PM with E1 (ED), E2 (DON) and E3 (ADON).	F 689		
F 944 SS=B	QAPI Training CFR(s): 483.95(d) §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that for six (E12, E15, E16, E21, E27 and E28) out of ten staff reviewed, the facility failed to ensure that the required QAPI (Quality Assurance And Performance Improvement) training was completed. Findings include: 8/27/24 - Review of the employee training records revealed a lack of evidence of QAPI training of the following staff: 11/18/21- E12 (RN) was hired by the facility. 1/20/22 - E28 (CNA) was hired by the facility. 3/7/23 - E15 (LPN) was hired by the facility. 7/25/23 - E16 (CNA) was hired by the facility. 8/8/23 - E21 (H) was hired by the facility.	F 944	Corrective Action: " Employees E12, E28, E15, E16, E21, and E27 remain members of staff in the facility. Corrective actions have been ensured by the Administrator and the Director of Nursing. The required staff training regarding Quality Assurance and Performance Improvement (QAPI) is ongoing for all staff. Identification of Other Residents: " All Residents have the potential to be affected. To prevent other residents from being affected, the facility will complete a 100% audit of all current employees to ensure that all training requirements have been completed including QAPI training. System Changes: " The Root Cause of the concern was a failure to ensure that the required QAPI	10/7/24

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F 944	Continued From page 24 10/3/23 - E27 (CNA) was hired by the facility. During an interview on 8/28/24 at 11:15 AM, E1 (ED) confirmed the above staff did not receive their required training. Findings were reviewed during the exit conference on 8/28/24 at 1:06 PM with E1 (ED), E2 (DON) and E3 (ADON).	F 944	training was completed. The facility policy for Staff Development Program (rev. 5.2019) was reviewed and found to meet professional standards. The facility system for managing the Staff Development Program has been updated to include a monthly review of compliance in the monthly Quality Assurance and Performance Improvement (QAPI) committee meeting. The administrator and the nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: " A Staff Development Program audit to ensure compliance with staff training requirements will be completed by the Director of Nursing or designee; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 949 SS=E	Behavioral Health Training CFR(s): 483.95(i) §483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and	F 949		10/7/24

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F 949	Continued From page 25 as determined by the facility assessment at §483.71. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that for seven (E8, E12, E15, E16, E21, E27 and E28) out of ten staff reviewed, the facility failed to ensure that the required Behavioral Health training was completed. Findings include: 8/27/24 - Review of the employee training records revealed a lack of evidence of Behavioral Health training of the following staff: 11/18/21- E8 (receptionist) and E12 (RN) were hired by the facility. 1/20/22 - E28 (CNA) was hired by the facility. 3/7/23 - E15 (LPN) was hired by the facility. 7/25/23 - E16 (CNA) was hired by the facility. 8/8/23 - E21 (H) was hired by the facility. 10/3/23 - E27 (CNA) was hired by the facility. During an interview on 8/28/24 at 11:15 AM, E1 (ED) confirmed the above staff did not receive their required training. Findings were reviewed during the exit conference on 8/28/24 at 1:06 PM with E1 (ED), E2 (DON) and E3 (ADON).	F 949	Corrective Action: " Employees E12, E28, E15, E16, E21, and E27 remain members of staff in the facility. Corrective actions have been ensured by the Administrator and the Director of Nursing. The required staff training regarding Behavioral Health is ongoing for all staff. Identification of Other Residents: " All Residents have the potential to be affected. To prevent other residents from being affected, the facility will complete a 100% audit of all current employees to ensure that all training requirements have been completed, including Behavioral Health training. System Changes: " The Root Cause of the concern was a failure by the facility to ensure that the required Behavioral Health training was completed by staff. The facility policy for Staff Development Program (rev. 5.2019) was reviewed and found to meet professional standards. The facility system for managing the Staff Development Program has been updated to include a monthly review of compliance in the monthly Quality Assurance and Performance Improvement (QAPI) committee meeting. The administrator and the nursing management team will provide oversight to ensure ongoing compliance.	

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F 949	Continued From page 26	F 949	Success Evaluation: " A Staff Development Program audit to ensure compliance with staff training requirements will be completed by the Director of Nursing or designee; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	