

**Iowa Department of Inspections and Appeals  
Health Facilities Division  
Citation**

Citation Number: #10015		Date: September 11, 2023		
Facility Name: Heritage Specialty Care		Survey Dates: July 27 – August 16, 2023		
Facility Address/City/State/Zip: 200 Clive Drive SW Cedar Rapids, IA 52404		JS		
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

<b>56.6(1)</b>	<b>481—56.6(135C) Treble and double fines.</b> <b>56.6(1) Treble fines for repeated violations.</b> The director of the department of inspections and appeals shall treble the penalties specified in rule 481—56.3(135C) for any second or subsequent class I or class II violation occurring within any 12-month period, if a citation was issued for the same class I or class II violation occurring within that period and a penalty was assessed therefor.	I	<b>\$24,750 (\$8,250 x 3) (Held in Suspension)</b>	<b>Upon Receipt</b>
<b>58.28(3)e</b>	<b>481—58.28(135C) Safety.</b> The licensee of a nursing facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. <b>58.28(3) Resident safety.</b> e. Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III)  <b>Description:</b>  Based on clinical record review, staff interviews, family interviews, resident interviews, policy review, and observations the facility failed to provide adequate supervision for 2 of 5 residents reviewed for adequate supervision (Resident #21 and #26). The facility failed to ensure the resident's safety by allowing Resident #21 to leave			

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	<p>the facility with a male friend without the consent and knowledge of the resident's Guardian and failed to ensure a resident's safety by failing to complete a thorough search of the premises after a Wander guard alert system sounded. The facility reported a census of 152 residents.</p> <p>Findings include:</p> <p>1. According to Resident #21's face sheet upon admission to the facility, the resident had diagnoses which included Dementia with behavioral disturbances, Chronic Obstructive Pulmonary Disease, dysphagia-pharyngoesophageal phase (swallowing problems), suicidal ideation's, alcohol abuse, and major depressive disorder. The face sheet revealed the resident had an admission date of 2/8/2022 and directly admitted to the secure locked unit. The residents' daughter is the emergency contact person as well as her appointed Guardian.</p> <p>According to the Quarterly Minimum Data Set (MDS) dated 7/26/23, Resident #21 had a Brief Interview for Mental Status (BIMS) score of 6 which indicated severe cognitive ability. The resident moved about the unit independently and</p>			
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	<p>completed Activities of Daily living independently with oversight from the staff. The resident experienced 1 fall since admission without injury and receives antidepressant and antipsychotic medications daily.</p> <p>Review of a Care Plan dated 3/2/22 indicated the resident resisted cares and refuses to allow staff to help her at times. The Care Plan informed the staff Resident #21's daughter is her Guardian and emergency contact. The Care Plan alerted the staff that on 7/22/23 the resident went out with a family member, she and the family member did not have a clear return plan and the local police department was notified.</p> <p>Review of a Progress Note by Staff A-RN dated 7/22/23 indicated at approximately 1:00 pm the resident had a visitor arrive at the facility. Resident #21 told the staff her former brother-in-law was coming to the facility to see her. The front desk contacted Station 2 nurses' station to alert staff the visitor had arrived. When the visitor arrived to the unit, the resident had her purse and a bag in hand. The male visitor carried the bags and they left the unit together. The nurse indicated she was unaware the resident had not signed out</p>			
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	<p>of the unit either at Station 2 or at the front desk. At approximately 9:50 pm Staff A-RN contacted the charge nurse to report Resident #21 had not yet returned from her visit and they do not have any contact information of the male visitor who took the resident out of the facility.</p> <p>Review of a Progress Note by Staff B-LPN/Assistant Director of Nurses dated 7/22/23 at 10:34 pm revealed she received a phone call from Resident #21's responsible nurse who reported the resident left the facility today and has not yet returned. Staff B-LPN placed a phone call to the resident's guardian to request a phone number for the male visitor who took the resident out of the facility on the day shift. The guardian stated she did not have the telephone number but possibly her brother did. Staff B requested the guardian call her brother to get the telephone number.</p> <p>Review of a Progress Note by Staff B-LPN/ADON dated 7/22/23 at 11:40 pm, the guardian stated her brother contacted the male visitor who indicated he would have the resident back at the facility by midnight.</p>			
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	<p>Review of a Progress Note dated 7/23/23 at 6:08 am, Staff B-LPN alerted the local police department, informing them of Resident #21's failure to return to the facility.</p> <p>Review of a Progress Note by Staff C-RN dated 7/23/23 at 10:49 am, Resident #21 returned to the facility today at 10:30 am. The note indicated the resident refused to have an assessment completed upon return to the facility. Staff C-RN falsely documented Resident #21 did have permission from her son to go out of the facility with the male visitor the day prior.</p> <p>Review of a Progress Note dated 7/23/23 at 12:10 pm by Staff C-RN, the staff nurse indicated several hours after the resident returned to the facility at 10:30 am, she made a comment she wanted to die. The staff placed the resident on 15 minute checks for closer supervision. Staff C-RN stated she contacted the Primary Care Physician regarding the comment on 7/23/23 at 12:05 pm.</p> <p>During an interview with Resident #21's Son on 7/31/23 at 4:00 pm revealed the son did not give permission for his mother to leave the facility with her former Brother-in-law on 7/22/23. The Son</p>			
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	<p>stated he was made aware his mother failed to return to the facility on 7/22, he called her the following morning at the former Brother-in-law's home and informed her she had to return to the facility that morning.</p> <p>During an interview with Resident #21's guardian and contact person on 7/31/23 at 2:00 pm, the guardian stated she received a phone call from Staff B-LPN/ADON on 7/22 at 10:15 pm, she was informed her mother hadn't returned from a off grounds visit with her former Brother-In-Law. The guardian made Staff B aware that she had no knowledge her mother went anywhere off the unit nor did she give permission for her to leave the facility. She stated she then received a call the following day to inform her that they placed her mother on 15 minute checks for suicidal ideation's. The guardian stated she spoke to the Administrator and Director of Nurses on Monday, 7/24/23 asking them if they reported the incident to the Department of Inspections and Appeals, they made the comment they thought this was an authorized visit. The guardian informed them this was not an authorized visit, she did not approve the visit. She voiced frustration with the lack of</p>			
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	<p>communication with her regarding the details of the incident with her mother.</p> <p>During an interview with the Primary Care Provider on 8/2/23 at 11:06 am, the PCP stated she was on call the weekend of the incident and did not receive any notification that the resident left the building with her former Brother-in-law on 7/22/23 and failed to return until the following morning. She stated the resident would have missed several doses of her antidepressant and antipsychotic medications which would not make her feel well. The PCP also stated the resident is on a pureed diet and is a choking hazard. The PCP continued to say she is sure the resident's guardian would not have been okay with her mother going out of the building with the male visitor due to her history of alcohol and drug misuse.</p> <p>During an interview with Staff D-Registered Dietician (RD) on 8/2/23 at 1:07 pm, the RD stated the resident is on a physician ordered pureed diet and is at risk of choking.</p> <p>During an interview with Staff C-RN on 8/2/23 at 8:20 am, the RN stated she worked on the locked Dementia Unit with an Agency RN on dayshift,</p>			
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	<p>7/22/23. Staff C stated she was the primary nurse on A Hall and not responsible for Resident #21's care that day. Staff C stated earlier in the morning of 7/22 she witnessed Staff A-RN assist Resident #21 with a phone call. Later in the morning (time unknown by Staff C) the receptionist called back to the unit, alerting them Resident #21 had a visitor at the front entrance. Staff C asked an aide to take the resident to greet the visitor at the entrance. Staff E-Certified Nurse Aide (CNA) walked the resident to the entrance to greet her visitor and they all returned to the locked unit. The male visitor approached Staff C-RN and informed her he was taking Resident #21 out of the facility. Staff C stated she inquired if the resident could leave the unit with the male. Staff A-RN told Staff C-RN that yes, the resident could go out of facility. Staff C stated she assumed everything was taken care of and the resident could go with the male visitor. When the resident and male visitor left the unit, the resident had her purse and bags of personal belongings. Staff C handed the sign out log to the male visitor who put his name and address on the form. The Resident and the male visitor left the unit together. Staff C-RN stated she did not send any medications or give the resident and male friend</p>			
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	<p>any instructions, stating she was not the primary nurse for Resident #21.</p> <p>Staff C-RN stated she worked on the locked Dementia Unit the following day (7/23), when she arrived on the unit the next morning a local police officer was on the unit speaking with Staff B-Assistant Director of Nurses. Staff C learned at that time the resident failed to return to the facility on 7/22/23. The police officer informed the staff he was going to put out a missing persons report if she did not return soon. Staff C indicated the resident returned back to the facility at approximately 10:30 am, upset about having to return to the facility.</p> <p>Staff C-RN stated she was terminated from her employment at the facility on 7/25/23 but does not understand the reason. Staff C did admit the failure was partially because she did not call the resident's guardian to get permission for the leave. Staff C-RN stated Staff A-RN was an agency nurse but thought she had taken care of everything prior to the resident leaving the facility. Staff C-RN admitted she knew the resident had a guardian prior to this incident but again stated she was not the resident's primary nurse and she "figured" the other nurse took care of everything.</p>			
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	<p>During an interview with Staff E-CNA on 8/1/23 at 9:00 am, Staff E stated she was working the day shift (7/22) on the locked Dementia Unit. She was in the hall when she was approached by the resident and a male visitor. Both the resident and the male visitor had plastic bags with the resident's belongings, she indicated about 6 bags of belongings between both of them. The male visitor approached Staff E and asked her for the door code. Staff E did not give them the code but opened the door herself after asking both nurses, is it okay to let them out, they have a lot of bags. Both of the nurses replied yes, Staff E clarified the answer a second time and again they replied yes. Staff E entered the code and the resident and male visitor left the unit together. Staff C-RN informed Staff E they said they would be back before midnight. Staff E stated why would they have a lot of bags, it looked like they were moving out. Staff E finished her shift that day at 10:30 pm, the resident had not yet returned to the facility when she went home. Staff E returned to work the following day at 6:00 am and learned the resident had not returned to the facility as she said she would. Staff E stated the resident returned the morning of 7/23, she appeared like herself but very upset about having to return to the facility.</p>			
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	<p>Staff E-CNA was glad to see her back as she was worried she was dead somewhere, that she may have choked on regular food stating the resident receives a pureed diet or that maybe she drank alcohol or took some street drugs.</p> <p>During an interview with Staff A-RN on 8/2/23 at 9:00 am, Staff A stated she was an agency nurse assigned to work the dayshift on 7/22/23 in the locked Dementia Unit. She indicated on 7/22 Resident #21 was talking about getting a visit from her former Brother-in-Law that day and excited to see him. At approximately 12:30 pm, the Charge Nurse Staff C-RN informed Staff A she was going to take Resident #21 up to the front entrance to greet a male visitor, but at the last minute she asked a CNA to escort her. The aide escorted the resident to the entrance and shortly returned with the resident and male visitor to the unit. Staff A indicated she heard the male visitor say to Staff C-RN that he was taking the resident out. The two left the unit, the male visitor noted to be carrying several bags of the resident's belongings. Staff A overheard the male visitor state to Staff C-RN that he would have the resident back in several hours. Staff A stated she assumed since Staff C-RN worked at the facility</p>			
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	<p>full time she took care of the arrangements for the leave. Staff A-RN stated Staff C-RN ended her shift at 2:00 pm leaving Staff A-RN to work the unit alone until the end of the evening shift. Staff A passed medications to other residents but kept watching the clock, awaiting the return of Resident #21. At approximately 6:45 pm the resident still had not returned to the facility and hoped she would return soon as she did not have any of her medications for lunch or evening. Staff A-RN stated she pulled up the resident's face sheet and noted the male visitor was not listed on the form, so she did not have any contact information to call the visitor to inquire about the whereabouts of the resident. Staff A checked the sign out sheet and the resident did not sign out prior to leaving the building. Staff A called Staff F-LPN/Charge Nurse and alerted her of the situation and the resident was seen leaving with several bags of belongings. Staff A voiced her concern to Staff F concerned that the resident had not yet returned. Staff F directed Staff A to call Staff B-LPN/Assistant Director of Nurses to alert her of the situation. Staff A indicated at the end of her shift she gave report to the on-coming nurse and informed her if the resident did not return by morning they are to alert the local police</p>			
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	<p>department. Staff A-RN stated Staff C-RN was responsible to verify if the resident had the appropriate approval to leave the unit because she was the Charge Nurse.</p> <p>During an interview with Staff E-LPN/Charge Nurse on 7/22/23 evening shift. Staff E stated she received a phone call from Staff A-RN informing her we have a problem. She informed Staff E Resident #21 left on the day shift and had not yet returned to the facility. Staff E directed the RN to call Staff B-LPN/Assistant Director of Nurse. Staff A notified Staff B at 9:52 pm. Staff E stated Staff B asked her who took out the resident? replied a male visitor. Staff B asked who gave them permission to leave, Staff E replied Staff C-RN gave permission. Staff E stated she came back to the unit that day about 1:00 pm for another reason and met Resident #21 and a male visitor at the door trying to leave. Staff E asked Staff C-RN if it was alright for them to leave, Staff C stated yes. Staff E stated she had never seen this male visitor before and has never known the resident to leave the building with anyone before today. Staff C stated the resident and male visitor indicated they would return before midnight on 7/22.</p>			
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	<p>During an interview with Staff G-RN/Director of Nurses on 8/1/23 at 8:30 am, the DON revealed she received a phone call from Staff B-LPN/ADON on 7/22/23 at 10:00 pm, she informed the DON a male visitor took Resident #21 out of the facility without family approval or knowledge and had not yet returned. The DON stated the male visitor was not on the resident's face sheet to visit and should have not been allowed to leave the facility without the guardian's permission or knowledge. Staff G stated she spoke to the resident's guardian about the situation on 7/22/23, the guardian stated she should have been notified and she would not have allowed her Mother to leave with the male visitor.</p> <p>During an interview with Staff B-LPN/ADON on 7/31/23 at 1:30 pm, the staff stated she worked on Saturday, 7/22/23 in her office, directly next door to the locked Dementia Unit. Staff B stated she knew the resident could only leave the unit with her daughter/guardian or her son. The policy for allowing residents off the unit is the facility staff must check the resident's face sheet to see if the person is on the approved list of visitors and if able to take the resident out of the unit. If the name of the visitor is not on the face sheet the</p>			
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	<p>staff must call the resident's responsible person to get permission. Staff B-LPN stated the resident resides on the locked unit and a reasonable staff person should have checked to assure they have permission to visit off the unit. Staff B shared she received a phone call the night of 7/22 at about 9:50 pm alerting her to the situation, the resident left the facility with a male visitor and had not yet returned. Staff B contacted the residents guardian in an attempt to get a contact number for the male visitor who took the resident out, the guardian did not have it but thought possibly her brother did. The residents' son alerted of the situation, texted the male visitor and confirmed the resident was with the male friend. The facility made aware the location of the resident. The local police were contacted early in morning of 7/23 and arrived to the facility at approximately 5:50 am to take the report.</p> <p>During an interview with Staff H-Certified Medication Aide on 7/31/23 at 3:00 pm, Staff H stated on 7/22/23 at about 1:30 pm he witnessed Resident #21 and a male visitor walking down the hall with several bags of clothing. He reported he did not see her leave but worked until 8:00 pm that night on the locked unit and she did not return</p>			
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Facility Administrator

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Date

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	<p>while he was working that day. Staff H reported coming to work the next morning (7/23) and was told in morning report she failed to return yesterday. At about 10:30 am Staff H made phone contact with the resident, the resident stated she was at a friends house and was not returning to the facility. The resident gave Staff H the address of the male friend. Staff H asked to speak to the resident's friend, Staff H informed the male friend the resident needed to return to the facility. The resident's male friend kept saying she refuses to return, Staff H stated if she does not return the facility the police will get involved. Staff H reported the resident returned approximately about 11:00 the morning of 7/23. The male visitor dropped the resident off at the front door, gave her a kiss and quickly ran away. Staff H shared the resident kept verbalizing she was not going to stay at the facility and repeatedly packed her bags to leave again. Monday morning (7/24) Staff H asked Staff C-RN how the resident was allowed to leave the facility, Staff C stated it was Staff A-RN's fault, she approved her leaving.</p> <p>Review of a police report dated 8/23/23 revealed that at 1:00 pm on 7/22/23 a staff nurse allowed Resident #21 to leave the building with a male</p>			
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	<p>friend. The male friend was not on the approved list of visitors. Staff B-LPN/ADON informed the officer the facility had standard procedure that if someone was not on the list they need to contact the guardian or emergency contact person listed and get approval. The nurse informed the officer no one contacted the guardian. The officer told the guardian if her mother is not returned back to the facility by noon 7/23 he will file a missing persons report.</p> <p>Review of a policy dated 9/2017 titled Orders Related to Leaves of Absence from the Facility, the policy informs staff that nursing staff shall authorize leaves of absence appropriately, including medications, equipment or services that the resident may require during their absence from the facility. The policy states the residents will be able to have appropriate leaves, once the resident's responsible party, power of attorney has been verified. Residents will not experience problems due to the lack of medications while on leave.</p> <p>2. According to Resident #26's Minimum Data Set (MDS) dated 8/4/23, the resident had diagnoses which included fractures, coronary</p>			
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	<p>artery disease, diabetes mellitus, chronic obstructive pulmonary disease, functional quadriplegia, and falls with injuries. The Resident had a Brief Interview for Mental Status (BIMS) score of 12 which indicates moderate cognitive impairment. The resident had total dependence of 2 staff for transfers and extensive assistance of 2 staff for dressing and personal hygiene, impairment of both lower limbs and utilizes a wheelchair for moving about the facility. The resident did not walk.</p> <p>Review of the Care Plan dated 3/27/23 with a revision noted on 8/15/23, informed the staff Resident #26 is an elopement risk and likes to go outside. The Care Plan indicated the resident sometimes leaves the facility unattended and directed the staff to be alert to his wandering behaviors and distract him from wandering by offering him diversions. The Care Plan indicated the resident wore a Wander guard alert system and directed staff to change the Wander guard every 90 days or as needed.</p> <p>Review of an Incident Report dated 8/14/23 Resident #26 eloped from the facility on 8/10/23. The report indicated the resident noted to be exit</p>			
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	<p>seeking and went out the Station 4 door. At the time of the elopement, information relayed from a staff member revealed they did not feel the incident was an elopement because staff were with him. The Administrator reviewed the incident on 8/14/23 and determined it was an elopement, the facility began a correction action plan, which included all staff elopement re-education initiated, an internal investigation initiated, elopement drills conducted, review of the resident's Care Plan, the residents' family and Primary Care Physician notified of the elopement on 8/14/23 at 7:10 pm. During staff interviews the resident stated at the time of the incident he wanted to go outside for some fresh air. Staff identified a predisposing situation factor was the resident had active exit seeking behaviors.</p> <p>During an interview with Resident #26 on 8/15/23 at 1:00 pm, the resident questioned about the day he recently left the building, he stated he cannot remember the date but does remember going outside. When asked how he got out of the building he stated he left the building with a family member but does not know who they were and could not identify them if he saw them again.</p>			
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	<p>He stated he sat outside alone and liked being outside.</p> <p>Review of a Progress Noted dated 8/14/23 at 7:09 pm revealed the following entry: On 8/10/23 Resident #26 noted to be exit seeking and went out the facility door on station 4. Information obtained at the time of the alleged incident it was not felt to be an elopement and no injury was noted to resident. No further investigation was identified as necessary at that time. It was brought up to the administrator as an alleged elopement during a complaint survey on 8/14/23. The residents Primary Care Physician and wife were notified.</p> <p>During an interview with Staff L, Traveling Administrator on 8/16/23 at 7:00 am, the Administrator stated the incident with Resident #26 eloping from the building occurred on 8/10/23. She stated she became aware on 8/14/23 at 1 pm of a different version regarding the elopement. She was initially told on 8/10/23 by Staff G-RN the resident went outside the building but had a staff member with him, so she felt at that time no further investigation needed to be done. She stated on 8/14/23 she learned of another</p>			
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	<p>story, the resident noted alone outside in his wheelchair, without staff present. Staff L began another investigation and interviewed Staff G-RN again, during the second interview on 8/14/23, Staff G-RN admitted she turned off the Wander guard alarm without going outside to see if any residents were outside.</p> <p>During an interview with Staff G-RN on 8/14/23 at 12:00 pm, Staff G stated she was working on Station 4 on 8/10/23. She was in a resident room when she came out finding a group of people standing at the Station 4 entrance. She indicated the Wander guard alarm was sounding. She went to the door and attempted to shut off the alarm but did not know the Wander guard alarm code to deactivate the alarm. Staff M-Physical Therapist gave her the Wander guard code and at that time she shut off the sounding alarm. Staff G stated she did not go thru the vestibule and out the outside door to check to see if any residents were in the area. She stated she only glanced out the interior door while shutting off the alarm. She left the area and continued working. She went toward the nurses' station and noted Staff N-RN running down the hall. Staff N stated Resident #26 is outside alone in the parking lot. Staff asked</p>			
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	<p>Resident #26 who let him outside, he stated a family member but doesn't know who. During a second interview with Staff G-RN on 8/14/23 at 1:20 pm, Staff G stated she shut off the Wander guard alarm using the key pad on the left side of the 1st door. She stated it was approximately 20 minutes later when she noted Staff N-RN running down the hall, stating Resident #26 is outside alone. Staff G stated the incident happened on 8/10/23 at approximately 11:00 am.</p> <p>Review of Staff G-RN personal file revealed a Corrective Action Form dated 8/15/23, review of the corrective action form revealed the staff received disciplinary action due to the following: On 8/10/23 Staff G-RN did not follow elopement wandering policy. She disengaged the alarm and did not complete a full investigation.</p> <p>During an interview with Staff N-RN on 8/15/23 at 11:00 am, Staff N stated she was making rounds on 8/10/23 with Housekeeping Supervisor on the south west hall on Station 4. She looked out the window and saw Resident #26 sitting outside alone in his wheelchair. The resident noted to be sitting at the south end of the parking lot, no one around him while there. She ran down</p>			
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	<p>the hall and outside to retrieve the resident. When she approached the exit door the alarms were not sounding. She brought the resident back into the building, at the time they entered thru the Station 4 doors the Wander guard alarm sounded. The resident has a Wander guard placed on the bottom of his wheelchair. Staff N inquired who wheeled him out, the resident replied he did not know.</p> <p>During an interview with Staff O-Housekeeping Supervisor on 8/15/23 at 1:40 pm, Staff O stated she was making rounds with Staff N-RN on 8/10/23 sometime late morning. They were on the B Hall of Station 4 when they looked out the window. Staff O asked Staff N if that was Resident #26 sitting out in the parking lot, Staff N confirmed it was the resident. Staff N and Staff O ran to the parking lot and noted the resident sitting in his wheelchair alone, without his oxygen on. Staff N and O returned the resident to the building. When they left the building to retrieve the resident the door alarms were silent, upon return into the building the Wander guard alarm sounded. Staff O stated about 10 minutes prior to seeing the resident outside she heard the Wander guard alarm sound but was quickly silenced.</p>			
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	<p>During an interview with Staff M-PT on 8/14/23 at 2:00 pm, Staff M stated he was walking down the hall and heard the Wander guard alarm sounding. He stated someone was by the door so he thought the situation was handled and he proceeded to the PT room. He stated Staff G-RN stood by the door and asked him for the Wander guard code to enable her to shut off the alarm, he gave her the code and walked off. Staff M stated there had been several times lately he noticed the resident wheel himself towards the exit door but staff intervene and bring him back to the day room.</p> <p>Review of a Wandering and Elopements Policy dated March 2019. The policy statement included 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. The policy directs the staff to check resident's Wander guard devices daily for proper functioning. If a resident is missing, the staff are to initiated the elopement/missing resident emergency procedure: determine if the resident is out on an unauthorized leave, if resident not authorized to leave, initiate a search of the building and premises and if not</p>			
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	<p>located, notify the appropriate people. When the resident returns to the facility, the Director of Nursing Services or Charge Nurse will examine the resident for injuries, contact the attending physician and report findings and condition of the resident, notice to the resident's legal representative, notify search teams the resident was found, complete an incident report and document relevant information in the resident's medical record.</p> <p><b>Facility Response:</b></p>			
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