DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0127	A. BUILDING: _____ B. WING _____	C 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET PARK PLACE	3730 PENNSYLVANIA AVE DUBUQUE, IA 52002

(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
A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 42 Number of tenants with cognitive impairment: 10 *Total census: 52* The following regulatory insufficiency was cited during the investigation of Incident #110009-I and Complaint #112069-C:	A 000		
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to follow its policies and procedures related to elopement, door alarm response, visual checks and keys/door codes for *1 of 1 tenants reviewed* who eloped (Tenant #1). Findings follow: 1. Review of an electronic incident report indicated on 12/28/22 at 4:30 a.m. Tenant #1 eloped. The report indicated staff had delivered a newspaper to her at 3:40 a.m. and Tenant #1 was asleep. Staff finished delivering newspapers. At approximately 4:05 a.m. Tenant #1's apartment door alarm went off and staff checked her apartment, which was empty. Staff heard an alarm and checked the door. The staff "looked both ways and did a parameter check." Staff did not see anyone and called Tenant #1's name but	A 150	The Plan of Correction is attached	

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A 150	Continued From page 1 no one responded. Staff then checked the interior of the building. At 4:30 a.m. staff received a telephone call from a woman who had Tenant #1 in her car and she was not unable to get back inside. Staff responded to the door. Tenant #1 was wearing pajamas, gripper socks and had a throw blanket around her shoulders. Tenant #1 said she wanted to leave and once she was outside she could not get back inside. She went to the front door and was not able to get inside. She went to the street and flagged down a car to help. She was assisted to her apartment and her gripper socks were changed. Her feet and skin were checked for injuries and there was nothing noted. Staff was directed by the Healthcare Coordinator (HC) to send Tenant #1 to the hospital via ambulance. Tenant #1's family was contacted. A call was made to the hospital to check for a urinary tract infection (UTI) due to confusion. A handwritten incident report indicated the date and time of the incident was 12/28/22 from 4:21 a.m. to 4:30 a.m. It was not witnessed. The description of the incident indicated Tenant #1 left her apartment and flagged down people on the side of the street. A couple found her on the side of the street and brought her back. She was found wearing pajamas and socks. Her vital signs were as follows: temperature was 97.6, pulse was 61, respiratory rate was 16, blood pressure was 221/89 and oxygen saturation was 96%. It was noted Tenant #1 was wearing "improper or no footwear" and had on gripper socks. The report indicated Tenant #1 was cold from being outside and did not sustain any injuries. Tenant #1's feet were checked; they were cold but no injuries were noted. Staff A notified the HC at 4:40 a.m. on 12/28/22. The HC called 911 at 5:34 a.m. Tenant #1's primary care provider (PCP)	A 150		

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A 150	Continued From page 2 was notified at 7:30 a.m., the Director was notified at 4:46 a.m. and attempts to notify the family were made 4:47 a.m., 4:55 a.m. and 5:40 a.m. Tenant #1's family called back at 7:02 a.m. The Program's Internal Investigation document indicated on 12/28/22 at approximately 3:50 a.m. Tenant #1's apartment door alarm went off and Staff A responded. Staff A checked her apartment and Tenant #1 was not in the apartment. At 3:51 a.m. the rear exit door alarm was "activated." Staff A checked the door and did not observe anyone "in visual sight." Staff A started to check the building. During the search Tenant #1 was returned to the Program at 4:20 a.m. by a person driving by. The findings indicated Staff A did not check the "entire outside perimeter of the building when responding to the outside door alarm." Staff A completed a visual check outside of the exterior doorway. It was noted Staff A did not check the "entire perimeter" of the building as she did not have her keys with her at the time Tenant #1 eloped. The conclusion indicated Staff A did not follow the elopement policy and procedure as the perimeter of the building was not checked when the alarm was reset. Tenant #1 was sent to the emergency department (ED) on 12/28/22 and visual checks were increased to every 30 minutes. Tenant #1 was hospitalized on 12/29/22 and treated for frostbite to her feet. Flashlights were added to the exit doors and retraining was completed related to the elopement policy, visual checks policy, door alarm response policy and "key protocol." A Critical Incident Report indicated at 3:59 a.m. Tenant #1 exited her apartment, went down the back stairs and exited the building. She tried to get back in but the door was locked. Tenant #1 went to the front door but it was also locked. She	A 150		

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A 150	Continued From page 3 walked to the top of the sidewalk by the street and flagged down a vehicle. Tenant #1 was brought back to the front of the building by the people in the vehicle who called staff to let Tenant #1 inside. When staff heard Tenant #1's door alarm, staff responded but the apartment was empty. Staff started checking the building. When the staff member was on third floor, the first floor alarm went off. When staff got to the first floor door there was no one there so staff yelled her name but no one responded. Staff continued to search and received a telephone call from the "driver of the car that she was in front of the building waiting for some (sic) to let her in 0430 am." Staff checked the door but did not check the "perimeter far enough and it is possible she might have seen if she did." It was noted the incident was preventable. It indicated Tenant #1 was sent to the ED and returned with no skin issues. The following day her bilateral feet were blistered and she was sent to the hospital. She was admitted for frostbite and a urinalysis was pending. A Prehospital Care Report from the ambulance company revealed the ambulance company was notified at 5:40 a.m. and arrived at the Program at 5:50 a.m. The ambulance left for the hospital at 6:22 a.m. The transfer of care was at 6:40 a.m. The ambulance was dispatched for "evaluation of cold exposure from the elements." - The report indicated emergency medical services (EMS) arrived were met at the front entrance by a staff who identified herself as the caregiver. She said that at 4:00 a.m. Tenant #1's alarm went off but she did not "immediately respond as she was attending to another resident." The staff said she was the only caregiver on duty at that time. She said a back door alarm then also alarmed. She responded to	A 150		

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A 150	Continued From page 4 that door, looked "around outside from the door entrance and did not see any thing (sic) or anyone around." Staff said she went to Tenant #1's apartment but did not see Tenant #1 in the apartment. The staff said she was only staff in the building and could not leave the building. At 4:30 a.m. she was contacted by a person from the community that had observed Tenant #1 on Pennsylvania Avenue near the school. Tenant #1 was wearing a short sleeved shirt, thin pajama pants and "thin ankle sport socks." The person returned Tenant #1 to the building in their private vehicle. It was "estimated pt had been exposed to outside elements with temperature of 32 degrees F for at least 30 minutes." Tenant #1 was taken to her apartment and her wet socks were removed, a pair of dry long socks were placed, and she was covered with blankets. Another staff in the memory care unit was contacted to obtain vital signs, the supervisor was contacted, who contacted the ambulance service. The other staff returned to the memory care unit and staff put together paperwork and waited for EMS at the front entrance. Staff "did appear emotionally upset as she spoke to EMS." - - When EMS arrived to Tenant #1's apartment, the door was locked and staff told them she had to get the keys from "another area in building." The report indicated staff ran to get the keys and EMS waited outside of the apartment door. It was noted the emergency exit was directly outside of the tenant's apartment door. Staff returned with the keys and confirmed to EMS that was the exit Tenant #1 used to leave the building. The tenant was oriented to self and place at present time. Tenant #1 reported "burning sensation bilaterally to feet." Tenant #1 said she woke up and she thought there was "something wrong with the building." Tenant #1 said she left the building via the emergency exit door next to	A 150		

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A 150	Continued From page 6 2. When interviewed on 1/10/23 at 5:55 p.m. Staff A said she worked on second and third shifts on the night of Tenant #1's elopement. She had worked 10:00 p.m. to 6:00 a.m. on the side where Tenant #1 resided. Staff A said Tenant #1 was sleeping when she last checked on her at approximately 2:30 a.m. or 2:40 a.m. She said about 3:40 a.m. she delivered newspapers. She heard Tenant #1's apartment door alarm on her pager. When she checked the bedroom door was closed but the apartment door was open. She could hear an alarm. Staff A said she did not know where the noise was coming from, but she could hear it and said it was blaring in her ears. She tried to figure it out, went to open it but the alarm would not stop. She called Staff C to get the door code and she shut off the door alarm. Staff A said she had her key but did not know the codes to the doors. Staff A said she opened the door, stuck her head out and did not see any footprints. She looked in the whole building. She called the HC and told him Tenant #1 was missing. She received a telephone at 4:30 a.m. and a lady said there was woman in the street by the school, flagging people down for help. She had a black and red checked blanket, pajamas and socks. She did not have her walker with her. As soon as Tenant #1 was back into the building the HC told her to take Tenant #1's vital signs and get her ready to go to the hospital. She changed her socks and had Staff B take her vital signs. She felt her feet and they were very cold so she put on dry socks. She went to the memory care unit while Staff B took her vitals and printed out information for Tenant #1. Tenant #1 had told Staff B she climbed out of the window, although she went out the door. Tenant #1 said she could not get back inside. Paramedics arrived and put her on a stretcher. She did not contact the staff in the memory care unit (regarding to help search)	A 150		

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A 150	Continued From page 5 her apartment. She traveled down a flight of stairs and went out another door that went outside of the building. Tenant #1 said the door closed behind her and she was locked out. Tenant #1 reported she could not find her way back inside and went to the "highway." It was noted the "highway" was Pennsylvania Avenue. Tenant #1 did not know how long she was outside but said "it felt like I was out there for hours. I thought I was going to die out there." Tenant #1 said someone brought her back to the building. - EMS completed their assessment and confirmed with staff Tenant #1 had the same clothes on except for the socks, which was a short sleeved thin pajama shirt and thin pajama pants and "green grip style socks." Her hands were "mildly cool to the touch." It was noted she "two small contusions to right hand." Tenant #1 did not know where the contusions were from. Both feet were "severely cold to the touch, pale, dry and stiff." There was "Sensation and mobility present. Mobility of pt moving toes did exacerbate pt sensation of burning feeling." It was noted Tenant #1's "Pedal pulses present but weak. Bottoms of feet dirty." Staff provided the socks she had worn outside which were an "ankle length thin sport sock. Socks dirty and wet." Tenant #1 was "mildly weak while ambulating short distance to cot." Her temperature was 97.7. Tenant #1 was covered up with a sheet and two blankets and a winter coat was placed over her and she was transported into the ambulance. The heat in the ambulance had been turned to a high setting prior to arrival. A hot pack was put under her heel and along the bottom of the feet. Another hot pack was placed over the dorsalis area of the feet over her socks. "Pt reported burning sensation subsided with rewarming. Pt now experiencing tingling sensation bilaterally."	A 150		

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A 150	Continued From page 7	A 150		

because the staff in that unit were not to leave. Staff A wrote an incident report and statement related to the elopement. Review of Staff A's written statement substantially corroborated her interview.

When interviewed on 1/10/23 at 11:48 a.m., 1/11/23 at 2:15 p.m. the Director said he received a telephone call from the HC on 12/28/22 after Tenant #1 was found (4:30 a.m. to 4:40 a.m.). He was told Tenant #1 went out of the building. Staff A did not see her and she checked inside the building. She checked outside the garage door but did not see her there. A person found her, contacted the Program by phone and staff met her at the front door. The Director and HC met with Staff A who said she went to the check Tenant #1's apartment door (alarm) and she was not in her apartment. Staff A then went to the garage door when that alarm went off. She opened the exit door (garage) and looked outside but did not see her. Staff A did not go out of the building because she did not have her key with her. She started looking in the building and a person called and said they had found Tenant #1. Staff A met the person at the front door. Tenant #1 had been up on the street corner and the person helped her and brought her to the building. Staff A called the HC. Tenant #1 was taken to the hospital. Staff A said Tenant #1 was wearing pajama pants, shirt, a shawl and socks. She was not wearing shoes and did not have her walker with her. Staff A said she last saw Tenant #1 a half hour before, when she was delivering newspapers. Tenant #1 left the building at 3:51 a.m. and returned at 4:20 a.m. Her feet had frostbite but there were no other injuries noted. The weather at the time was 30 or 32 degrees and there was no precipitation. He said when the alarm first goes off it is audible and goes to a

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A 150	Continued From page 8 pager. It would continue to alarm until it is reset and the page would also continue. He said elopement drills and retraining was completed and Tenant #1's visual checks were increased to every 30 minutes. He confirmed the perimeter of the building was not checked and Staff A did not have her keys with her at the time of the elopement. When interviewed on 1/10/23 at 10:50 a.m. and 1/17/23 at 2:01 p.m. the HC said he received a call between 4:20 a.m. and 4:40 a.m. about Tenant #1 being out of the building. That call was in progress when Staff A received another call from a lady (person who found Tenant #1) and she wanted staff to let her in. Tenant #1's apartment door alarm had gone off,. Staff A responded but Tenant #1 was not there. She checked her apartment and started looking. Staff A heard the back garage door alarm on first floor. She checked the door and yelled the tenant's name but did not see anyone. Staff A received a telephone call that a lady had Tenant #1 in her car out front. She had picked the tenant up and dropped her off. When back in the building Staff A changed her clothes, laid her in bed and warmed her up. He told staff to check her feet, notified the Director and attempted several times to contact Tenant #1's family. The ambulance was called to send Tenant #1 to the ED (Emergency Department). Tenant #1 was sent back with no new orders. When he assessed her feet they were both blistered and she was sent back to the ED and was admitted until 1/6/23. Tenant #1 was treated for a UTI and had new orders for wound care. The treatment was discontinued on 1/9/23. He said the weather was about 30 degrees with a light wind. Tenant #1 was found in pajamas, a long sleeved shirt and gripper socks. She had a blanket over her	A 150		

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A 150	Continued From page 9 shoulders. She was not wearing shoes and did not have her assistive device. Tenant #1 was last seen by staff at 3:50 a.m. when newspapers were delivered. She visualized Tenant #1 inside the apartment sleeping. He said the apartment door alarm was not audible but went to the pager. Exit door alarms were audible and it went to the pager. The alarm continued until physically reset. The length of time Tenant #1 was outside was approximately 25 minutes. He said the policies were followed except Staff A should have walked further away from the door when she yelled the tenant's name. He said he would like to see safety checks documented "as you go." Flashlights were put at the exit doors. Retraining with staff was completed and elopement drills were also completed. When interviewed on 1/10/23 at 3:05 p.m. Staff B said she was assigned to the memory care unit on third shift. At 5:00 a.m. Staff A, who was working in the general population side, said Tenant #1 had gotten out (of the building). She was in bed, warmed up, and the HC. Staff A asked Staff B to take Tenant #1's vital signs. She told Staff A what Tenant #1's vital signs were and went back to the memory care unit. Tenant #1's feet were cold and she said her feet felt like pins and needles. Staff B made sure she had warm socks on and she touched her feet, which were very cold. Staff B said staff in memory care did not have a pager and she did not hear any door alarms. She said Staff A did not request assistance (prior to the vitals) and staff could not leave the memory care unit. When interviewed on 1/17/23 at 9:17 a.m. Tenant #1's legal representative said she received a telephone call from the HC and he said Tenant #1 had left the building and had been taken to the	A 150		

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A 150	Continued From page 10 ED. Tenant #1 told her she did not know why she left the building and had no way to get back inside. The tenant made a trip to the front of the building and she knew she needed help. Tenant #1 told her that her feet were frozen and she could not feel the bottom of her feet. Tenant #1 did not see the pendant (located at the front door) and could not remember the code to the front door. She took the tablecloth, walked up to Pennsylvania Avenue and two vehicles stopped. The people in one of the vehicles brought her back and called the Program. She was told by the Director staff did not check the perimeter. He told her staff could not hear the alarm system and new equipment was in the budget. Tenant #1's legal representative said 911 was not called. 3. Review of Tenant #1's file revealed she was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. Tenant #1's diagnoses included type 2 diabetes mellitus with diabetic neuropathy and history of UTIs. The service plan dated 4/22/22 reflected she received visual checks eight times per shift and had an alarm on her apartment door. The service plan also reflected Tenant #1 wore "skid-free socks at bedtime." The Documentation Task Survey sheet for December 2022 reflected the visual checks on 12/27/22 at 10:00 p.m. and 11:00 p.m. were documented at 10:00 p.m. The visual checks for 12:00 a.m., 1:00 a.m., 2:00 a.m., 3:00 a.m., 4:00 and 5:00 a.m. were all documented as completed by Staff A at 5:00 a.m. Alarm records for Tenant #1's apartment door alarm (alarmed when the door was opened) showed Tenant #1's apartment door alarm went off on 12/27/22 at 6:11 p.m. The alarm records showed the apartment door alarm did not go off again until 12/28/22 at 3:50 a.m.	A 150		

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A 150	Continued From page 11 (when Tenant #1 exited her apartment). The eight visual checks scheduled per shift were not completed for Tenant #1. The checks were not completed as indicated on the service plan or per the policy and procedure as evidenced by the greater than nine hour time period between alarms when Tenant #1's apartment door was opened (6:11 p.m. to 3:50 a.m.) and the visual checks not being documented at the scheduled times. Continued record review revealed a hospital History & Physical documented indicated Tenant #1 was brought to the ED with bilateral foot wounds. Tenant #1 was seen in the ED the day prior after she had gotten out of the Program at approximately 4:00 a.m. and was found "wandering out in the cold barefoot." She complained of her feet being cold, she was warmed up at the Program sent to the ED for evaluation. At that time she was "stabilized and discharged back" to the Program. Tenant #1 returned due "concern of worsening condition of her feet showing peeling of the skin on bilateral soles." Tenant #1 complained of some pain but "not as bad as before." 4. Review of alarm records indicated the following: - On 12/27/22 at 6:11 p.m. Tenant #1's apartment door alarmed (event) - On 12/27/22 at possibly 6:12 p.m. (screen shot difficult to read) Tenant #1's door alarm was cleared (clear) - On 12/28/22 at 3:50 a.m. Tenant #1's apartment door alarmed (event) - On 12/28/22 at 3:51 a.m. the back garage door alarmed (event) - On 12/28/22 at 3:59 a.m. Tenant #1's apartment door alarm was cleared (from 3:50	A 150		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0127	A. BUILDING: _____ B. WING _____	C 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET PARK PLACE	3730 PENNSYLVANIA AVE DUBUQUE, IA 52002

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A 150	Continued From page 12 a.m.) - On 12/28/22 at 4:20 a.m. the records indicated "Visitor/Visitor." This was the pendant located between the front doors (event) - On 12/28/22 at 4:24 a.m. the main door exit alarmed (event) - On 12/28/22 at 4:25 a.m. the main door exit was cleared (clear) - On 12/28/22 at 4:27 a.m. Tenant #1's apartment door alarmed (event) - On 12/28/22 at 4:30 a.m. Tenant #1's apartment door was cleared (clear) - On 12/28/22 at 4:31:32 a.m. the back garage door alarm was cleared (from 3:51 a.m.) - On 12/28/22 at 4:31:35 a.m. the back garage door alarmed (event) - On 12/28/22 at 4:31:39 a.m. the back garage door alarm was cleared (clear) - On 12/28/22 at 4:34 a.m. the main door exit alarmed (event) - On 12/28/22 at 4:34 a.m. the records indicated "Visitor/Visitor" was cleared (from 4:20 a.m.) - On 12/28/22 at 4:34 a.m. the main door exit was cleared (clear) - On 12/28/22 at 4:45 p.m. Tenant #1's apartment door alarmed (event) - On 12/28/22 at 4:48 p.m. Tenant #1's apartment door was cleared (clear) 5. Observation on 1/10/23 from 2:20 to 2:27 p.m. and from 3:15 p.m. to 4:00 p.m. of the camera footage was completed. There was a difference noted from time stamp on the camera footage to actual time. At 4:00 p.m. actual time, the time stamp on the footage reflected 3:25 p.m. (time delay of approximately 35 minutes). The camera footage indicated the following: - On 12/28/22 at 3:24 a.m. (camera time; delay approximately 35 minutes) a woman, identified by the Director as Tenant #1, came down the stairs	A 150		

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A 150	Continued From page 13 into the stairwell on first floor. She was wearing a short sleeved shirt and pajama pants. She did not a have blanket or assistive device with her. She initially went into the first floor hallway door. She then walked back out of the first floor hallway door and pushed on the back garage exit door. - On 12/28/22 at 3:25 a.m. (camera time; delay approximately 35 minutes) Tenant #1 exited the back garage exit door and the exit door shut. - On 12/28/22 at 3:29 a.m. (camera time delay; approximately 35 minutes) Tenant #1 was observed on the footage walking by short white fencing that appeared to by the employee entrance. She left the sight of the camera and reappeared, before again leaving the sight of the camera. - On 12/28/22 at 4:04:06 a.m. (camera time; delay approximately 35 minutes) Staff A, as identified by the Director, first appeared on the video footage at the back garage exit door. She went to the key pad of the door and appeared to have a phone in her hand. She was not observed opening the door at that time. Staff A left and went to the first floor hallway door. - On 12/28/22 at 4:04:32-33 a.m. (camera time; delay approximately 35 minutes) Staff A returned and opened the back garage exit door very slightly. Staff A was not observed putting her head outside of the door, she was not observed stepping outside of the door, and she was not observed going outside of the door. - On 12/28/22 at 4:04:55-56 a.m. (camera time; delay approximately 35 minutes) Staff A was observed looking at/through the door from inside the building. - On 12/28/22 at 4:05 a.m. (camera time; delay approximately 35 minutes) Staff A left the area by back garage door and went into the first floor hallway door.	A 150		

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A 150	Continued From page 14 6. When interviewed on 1/10/23 at approximately 11:30 a.m. the HC said there were no tracks/footprints until half way up on the sidewalk (small parking lot on the west side of the building). The small footprints followed up the sidewalk to near the front door. The tracks went up on the other sidewalk to the corner (of Pennsylvania Avenue) and the tracks stopped on the corner of Pennsylvania Avenue. When observed on 1/10/23 at approximately 11:30 a.m. the possible terrain Tenant #1 traveled when outside of the building included Program sidewalks, parking lot and city sidewalks. It was reported Tenant #1 flagged down a car passing by on Pennsylvania Avenue. Pennsylvania Avenue was a west/east city street with a posted speed limit of 35 miles per hour (mph), unless during the time it was a school zone, and the speed limit was reduced to 25 mph. It had two lanes of traffic, one eastbound lane and one westbound lane, with turn lanes. The State Climatologist provided the following weather conditions on 12/28/22 at 3:50 a.m. to 4:30 a.m. in Dubuque: the temperature was 29 degrees, relative humidity was 71%, winds were from the south at 24 mph with gusts to 39 mph, the wind chill was 15 degrees, there was no precipitation and there were clear skies. 7. The Program's elopement policy and procedure indicated alarms would be placed in the apartments of tenants at risk of wandering. If the tenant left the apartment an emergency call would be activated, which notified staff to check on the tenant. The policy and procedure indicated if the exit door alarmed to check "promptly." It indicated to "thoroughly check inside and outside areas triggered by the alarm."	A 150		

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A 150	Continued From page 15 If a "potential elopement" had occurred and the tenant was not found staff were to check all areas of the interior of the building and outside of the door exited. If the tenant was not found the nurse or Director would notify local law enforcement. The nurse on duty would notify the tenant's family. The Program's Nurse Delegation for Door Alarm Response indicated a notification would be sent to staff (walkie talkie, tablet or pager) that a door had been "breached" or "opened." Staff should immediately walk to the door that was opened and observe the interior and exterior of the door. After determining who came in or left, the door alarm was to be reset. Review of a typed document provided reviewed staff needed to carry a "master key" with them at all times. This allowed staff to enter tenant apartments and to get in from the exterior of the building. The document also provided the door codes for the exterior doors. The Program's Nurse Delegation for Visual Checks indicated staff were to go to the apartment, knock on the door, enter the apartment, make "visual contact" of the tenant and document the check per the scheduled time. "The key is for residents to be viewed through out (sic) an entire shift and ensure resident safety." The document indicated visual checks were to be completed "as close to the scheduled time as possible." 8. In summary, Tenant #1, who had a GDS of four and an apartment door alarm, left her apartment at 3:50 a.m. and then exited the building at 3:51 a.m. It was estimated she was outside of the building for approximately 30 to 44	A 150		

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A 150	Continued From page 16 minutes (based on interviews, camera footage and alarm records). Tenant #1 had visual checks that were to be completed eight times per shift per her service plan. The visual checks on 12/28/22 from 12:00 a.m. to 5:00 a.m. were all documented at 5:00 a.m., which was after Tenant #1 was returned to the building. Alarm records also indicated Tenant #1's apartment door was not opened during the entire third shift on the night of elopement and had not been opened since 6:11 p.m. the day prior; despite eight visual checks scheduled per shift. Staff, including Staff A, did not complete visual checks per policy and procedure. larm records indicated Tenant #1's apartment door alarm went off at 3:50 a.m. and it was not cleared until 3:59 a.m. (9 minutes later). Alarm records indicated the rear garage exit door alarm went off at 3:51 a.m. and was not cleared until 4:31 a.m. (40 minutes later). Staff A did not respond to the apartment door alarm or the exit door alarm promptly. Per review of camera footage Staff A did not check the area outside of the exit door that triggered the alarm. The incident report indicated the Healthcare Coordinator was not notified until 4:40 a.m., approximately 50 minutes after the apartment door alarm went off and 49 minutes after the exit door alarm went off. Staff A did not follow the elopement policy and procedure or door alarm policy and procedure. Staff A also either did not have her keys and/or did not know the code for the exit doors. Staff did not follow the policy and procedure to carry a "master key" with them at all times and/or to have knowledge of the door codes. Tenant #1 traveled down a flight of stairs without her walker, dressed in a short sleeved shirt, pajama pants and socks and left the building. She walked from the back of the building to the front of the building in the dark on the sidewalk and through the parking lot. She	A 150		

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A 150	Continued From page 17 went to the front door, could not get in and took a tablecloth from the inside of the doors. She walked across the parking lot, up the sidewalk to Pennsylvania Avenue and flagged down a car passing by to help her. The person in the car called the Program and Tenant #1 was returned to the building. She was sent out to the hospital (an ambulance was called at 5:40 a.m., approximately an hour from the Healthcare Coordinator's notification). She initially went to the ED and returned with no new orders. The next day she was sent back to the ED and was treated for frostbite to her bilateral feet (Tenant #1 had a diagnosis of diabetes mellitus type 2 with diabetic neuropathy). Staff failed to follow multiple policies and procedures related to Tenant #1's elopement including, the elopement, door alarm, visual checks and key/code policies and procedures.	A 150		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER: S0127	DATE SURVEY COMPLETED: 1/18/2023

ID PREFIX TAG A 150	SUMMARY STATEMENT OF DEFICIENTCIES (EACH DEFICIENCY SHOULD BE PRECEDE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY	Identify what changes to the provider's systems and practices were made to ensure compliance with the specific statute(s). Include information about how the provider will maintain compliance in the future.	COMPLETION DATE
Tag #1	**Regulation and Reg Number 481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program.** This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the Program failed to follow its policies and procedures related to elopement, door alarm response, visual checks, and keys/door codes for 1 of 1 tenant reviewed who eloped (Tenant #1).	A 150	The community has completed re-training of staff that included elopement drills on all three shifts on December 29th and December 30, 2022. Re-training of staff regarding elopement policy, visual check policy, door alarm response, key policy and codes for door exits were reviewed with staff on December 29th and December 30, 2022.	*The Program Director, Nurse or designee will ensure elopement drills will be conducted quarterly.* *Elopement policy, visual check policy, door alarm policy, key policy, and codes for door exits training completed upon hire and annually for staff.* *Continued monitoring of door alarms response, visual checks will be audited by Community Director or designee.*	Implementation Date: 12/29/22 Completion Date: Ongoing Responsible Party: Director or Designee

Date of Compliance: 3/31/2023

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of regulatory insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.

ok 3/31/23