DEPARTMENT OF INSPECTIONS AND APPEALS

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0195	A. BUILDING: _____ B. WING _____	C 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE CEDARS MEMORY CARE	6325 ROCKWELL DRIVE NE CEDAR RAPIDS, IA 52402

(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 disorder: 1 Number of tenants with cognitive disorder: 13 TOTAL Census of Assisted Living Program for People with Dementia: 14 Incident #112364-I was investigated and the following regulatory insufficiencies were cited:	A 000	POC 7/31/23 Plan of Correction - Missing Persons 1. On June 20, 2023 the program provided retraining for all Health and Wellness staff regarding the Missing Persons Policy and Procedure dated September 30, 2016. 2. The Community updated its Missing Persons Policy and Procedure on June 21, 2023 and all health and wellness staff working subsequent to June 30, 2023 are required to be trained in and knowledgeable about the updated policy and procedure at the beginning of his or her first shift following such if not sooner trained. All other Community staff shall be trained in the updated Missing Persons Policy and Procedure no later than July 31, 2023. A copy of the updated Missing Persons Policy and Procedure dated June 21, 2023 is attached as Exhibit A. Director of Health and Wellness provided additional education on the updated Missing Persons Policy and Procedure to all health and wellness staff during an annual in-service training on June 26, 2023, June 27, 2023, June 28, 2023 and July 2, 2023. 3. The program will continue to provide education and training to all staff during staff delegations and mandatory staff in-services regarding the critical nature and importance of: (a) notifying all staff on duty, start a search of the building and grounds; (2) notification of the Executive Director or Director of Health and Wellness within 5 minutes as the staff member continues searching; and (3) if the resident is not located within 10 minutes, calling 911.	6/20/23 7/31/23 Ongoing
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. This pertained of 1 of 1 tenants reviewed who eloped (Tenant #1). Finding follows: Record review on 4/19/23 of Tenant #1's file revealed he had diagnosis that included Lewy Body Dementia without behavioral disturbance. Tenant #1 was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. Tenant #1's service plan dated 4/11/23, indicated Tenant #1 walked with a walker at all times. Tenant #1 was independent with ambulation and staff assisted as needed if he was unsteady or weak. For transfers, Tenant #1 was independent but staff	A 150		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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assisted if he was unsteady or weak. Tenant #1 received scheduled toileting assistance including on third shift. The service plan indicated to complete toileting on third shift. It indicated Tenant #1 would get up independently if he was not assisted with toileting at 1:00 a.m. The service plan reflected safety checks every two hours (related to wandering,elopement and supervision). The checks indicated to ensure Tenant #1 was safe and to give him water when he was awake. The service plan also indicated to make sure Tenant #1's walker was next to the side of the bed when he slept.

Continued record review revealed the April 2023 treatment administration record reflected the following:

a. On 4/15/23 at 7:29 p.m. Tenant #1 was assisted with toileting and it was noted he was incontinent of urine and was changed.
b. On 4/15/23 at 7:29 p.m. a safety check was completed and it was noted Tenant #1 was sitting in a chair in the common area.
c. On 4/15/23 at 8:51 p.m. Tenant #1 refused toileting assistance and it was charted Tenant #1 was sleeping.
d. On 4/15/23 at 8:51 p.m. the safety check reflected Tenant #1 was in bed.
e. On 4/15/23 at 11:11 p.m. the toileting assistance was charted as refused and it indicated Tenant #1 was sleeping.
f. On 4/15/23 at 11:11 p.m. the safety check reflected Tenant #1 was sleeping in bed.
g. On 4/16/23 at 1:47 a.m. (1:00 a.m. safety check) it was noted it was not completed as Tenant #1 had exited the building.

Further record reivew revealed incident reports indicated Tenant #1 eloped on 10/10/22 at 7:30

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A 150	Continued From page 2 p.m. and on 4/16/23 at 12:36 a.m. Record review on 4/19/23 of an Incident Report dated indicated on 4/16/23 at 12:36 a.m. an elopement occurred with Tenant #1. The incident report indicated at 12:00 a.m. a safety check was completed and Tenant #1 was sleeping close to the wall. The memory care west door alarm went off at 12:36 a.m. Staff responded and did not see anyone. Staff was not able to get the door alarm to turn off, she completed a head count and search. It was noted Tenant #1 was missing and staff contacted the medication aide from assisted living (AL) to assist. After a search of the outside, the Director of Health and Wellness (DHW) was called. Tenant #1 was found outside on the front side of the building. He was kneeling on his left knee in the grass. Tenant #1's vitals included: blood pressure was 114/64, pulse was 70, oxygen saturation was 93%, temperature was 96.9 degrees and respiration rate was 16. It was noted Tenant #1 did not sustain any injuries and walked back to his apartment with two staff. The incident report indicated the primary care provider (PCP) and family were notified. When interviewed on 4/19/23 at 1:50 p.m. Staff A said she checked on Tenant #1 at 12:00 a.m. and he was asleep in bed, the bed rail was up and his walker was next to his bed. She went to the nurse's station and she thought she heard another tenant who had been out at the dining room table. She heard a walker sound and thought it was that tenant. She said the alarm went off and the first time she said it was the front entrance door but she missed the west door alarm in the page. She said a second page went off again and it showed memory care west door. She checked the door and did not see anyone.	A 150		

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She did not go out of the door but opened the door and could not see anyone. She started a head count and realized Tenant #1 was missing. She informed AL staff Tenant #1 was missing and radioed for Staff B to come down to the memory care unit. The door alarm would not shut off. Staff A checked the building and walked around the building and he was not found. Staff A returned and then Staff B went to look for him and went the opposite way around the building. Staff B notified the DHW. After Staff B came back into the building, Staff A went back outside to look for him and he was located between the building and the cars in the grass. Tenant #1 was kneeling on one knee and did not have his walker with him. He was wearing pajama pants, a long sleeved shirt, shoes and socks. Staff A was able to get him up, his vital signs were taken and he had no injures. Tenant #1 returned to his apartment and went to sleep. She said the DHW made sure he was okay and checked the door alarms. Staff A said it was pretty chilly and windy. There was no precipitation. She completed an incident report. She said at the 11:00 p.m. check Tenant #1 was asleep in bed and she had not seen him awake on her shift prior to the elopement.

When interviewed on 4/20/23 at 5:39 a.m. Staff B said she worked second floor on the AL side from 10:00 p.m. to 6:00 a.m. (night of the elopement). Staff A was in the memory care unit. She said at 12:30 a.m. the memory care west door alarm came across the pager. She said usually staff called on the radio after the page went off but she said when it first went off she did not get a chance to radio right away. After 12:40 a.m. Staff A called on the radio to her and said she could not reset the door and she needed Staff B to come back and reset it. Staff B said Staff A did not tell her that Tenant #1 was unaccounted for at

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that time. Staff B came down to the memory care unit at 12:51 a.m. and Staff A said she did a head count and Tenant #1 was not accounted for; Staff B said it was the first time she was aware he was missing. Staff B went out the memory care west door toward the courtyard and went around the building and returned after not locating him. At that time Staff A went out of the building to look and Staff B tried to reset the door. She could not get the key to turn in the door. When Staff A was outside, Staff B checked the interior of the building. Staff A returned and was not able to find him and Staff B went back outside again and checked by the receiving area as he had gone there on a prior elopement. Staff B walked and looked up the sidewalk and came in to the front of the building on the right side. Staff B returned and called the DHW at about 1:20 a.m. Staff B said it was first time the DHW was notified Tenant #1 was missing. The DHW told Staff B to look around the entire building and she was told staff had been out multiple times. Staff A called her on the radio between 1:23 a.m. to 1:25 a.m. and said she had located Tenant #1 in the grass on his knees. He was located on the opposite side of the building (from where Staff B came in at). Staff A told her she saw Tenant #1's hair. Staff A requested assistance in getting Tenant #1 up. When Staff B arrived outside Staff A had already gotten Tenant #1 up and he was walking with Staff A. Tenant #1 did not have his walker with him. Staff B said Tenant #1 was in the building at 1:26 a.m. Tenant #1's vital signs were taken as he sat in the lobby and were within normal limits (WNL). He had marks on his skin from grass (indentations) and he had no injuries. His hands and fingers were cold. Tenant #1 was walked back to memory care. He was wearing fleece pajama pants, a long sleeved shirt and shoes. Tenant #1 was assisted with toileting and he was

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incontinent of urine, which was normal for him. She said the weather was a little chilly and it was misting. There was no snow on the sidewalk. She said there were a couple of pages going off that night, one tenant in the AL side lost the pendant and would not allow staff to look for it. It had been going off and continued to go off. She had not seen Tenant #1 prior to the elopement that night. She had not experienced any exit seeking with him; sometimes at night he did get up and wander. One time she found him in another tenant's apartment.

When interviewed on 4/20/23 Staff C said she worked first floor on the AL side, 10:00 p.m. to 6:00 a.m. (night of the elopement). At shift change were reports of issues with pagers in two apartments. There was a pendant that was continuously going off and could not be reset. She said between 12:00 a.m. and 1:00 a.m. the staff in the memory care called for Staff B to come to the memory care unit. Staff C said she saw the staff come and go and she asked Staff B what was going on and she reported Tenant #1 was missing. She was not told he was missing until she saw staff looking for him. She said Tenant #1 had a habit of needing to use the restroom at 1:00 a.m. and if it was missed he was confused and tried to urinate. Due to the one page that continuously went off it brought some confusion but she clarified and said really the door was the problem and it was not loud enough and it needed to be fixed.

When interviewed on 4/19/23 at 1:22 p.m. Staff D said she worked 2:00 p.m. to 10:00 p.m. on Saturday (4/15/23) in memory care. She said there was nothing abnormal for Tenant #1 on her shift. At the time of the last safety check at 9:00 p.m. he was asleep in bed. She said that was her

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last safety check and toileting check on her shift. She said he did not get up for toileting at that time. She said Tenant #1 did not give any prior indication of leaving. She said most of the time Tenant #1 slept in a chair in the common area. Staff D said on Saturday the main entrance door alarm to memory care would go off when no one was going through the door. She said it did it a few times on Saturday.

When interviewed on 4/20/23 at 9:48 a.m. the DHW said she received a telephone call at 1:24 a.m. on 4/16/23 from Staff B who reported Tenant #1 eloped. She directed staff to look around the entire building. The DHW called the ED and notified her. The DHW was on her way into the building and she received a telephone call from Staff B and they had found Tenant #1 and he was on his knee. Staff A was able to get him back into the building. The DHW arrived to the building at 1:32 a.m. and Tenant #1 was in the lobby and Staff A and Staff B were with him. Staff C was in the memory care unit. An assessment was completed and his vitals were WNL, he had no complaints of pain and was able to walk with stand by assistance on each side of him. Staff assisted him to the toileting and she assessed his knees, the left knee had indentations from the grass. His protective undergarment was damp but not soaked and it did not appear that he voided when on the toilet. Tenant #1's hands were chilly to the touch and his head and cheeks were not. There was no skin discoloration. He was wearing shoes, pajama pants and a long sleeved shirt. Tenant #1 went to bed at 2:00 a.m. The DHW left a message for family at that time and called family again in the morning. Tenant #1's spouse was also informed that morning. That night the DHW looked at the alarms and it alarmed at 12:36 a.m. and it took 40 minutes to

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A 150	Continued From page 7 clear. Tenant #1's bed rail was on the bed, the walker was next to the bed and it was determined he got out of bed at the foot of his bed. Staff A and Staff B said they were unable to silence the door but it was turned off before the DHW was called. The weather was 42 degrees, it was not raining on her way to the building but it had started raining on her way back home. The DHW came in the next morning at 8:15 a.m. and he had no complaints of pain, she reviewed the incident report and the PCP was faxed. The ED and DHW met with Staff A and she said she assumed it was the main entrance door because it had gone off inadvertently previously. When she visited with Staff B, she acknowledged that she did not hear an all clear (from memory care). Staff B heard from second shift that the AL door was inadvertently going off. Staff B also said at shift report staff reported alarms had been going off and were not clearing. It occurred for a tenant in the AL side who lost the pendant and would not let staff look for it and for a tenant in memory care that was not cleared. She said the AL tenant's alarm went off at 4:23 p.m. Neither the ED or the DHW had been notified of the issues with pagers not clearing. She said the first time she was made aware of the main memory care door alarm was on 4/16/23. Staff A was provided education on responding to the pagers immediately and not assuming anything. When interviewed on 4/20/23 at 11:24 a.m. the ED said she received a telephone call from the DHW around 1:20 a.m. to 1:40 a.m. informing her of the elopement with Tenant #1. She said the DHW called back and told her Tenant #1 was in the building. Tenant #1 did not have any injuries and his vital signs were good. The ED came into the building on 4/16/23. She said the DHW completed the self-report and the ED reviewed	A 150	Plan of Correction – Memory Care Door Alarms 1. On April 16, 2023 the program provided pager response re-education for all Health and Wellness staff ("Memory Care Pager Response") a copy of which is attached as Exhibit B. Each Health and Wellness staff member was retrained in and acknowledged by signature receipt of the Memory Care Pager Response training. 2. On June 20, 2023 the program provided re-training for all Health and Wellness staff regarding the Memory Care Door Alarms Policy and Procedure dated September 1, 2022, a copy of which is attached as Exhibit C. 3. The Director of Health and Wellness and nurses will provide ongoing training and re-education regarding alarm and pendant functionality during staff shift report and during delegations to ensure staff are: (a) knowledgeable about the operation of the alarm and pendant functions; (b) know how to clear alarms and pages from pendants appropriately;	

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A 150	Continued From page 8 camera footage. On 4/17/23 leadership staff went to memory care and reviewed the exit doors. She said the west and east doors alarms did not have a keypad and it was not a loud as she would like it to be. She said the alarm was very faintly heard from the nurse's station. She said an outside company was out to look at the doors and system at various times during the week. Also on Monday she and the DHW talked with Staff A. After additional video footage was reviewed, the ED saw for the first time Staff A take pillows and shut the door to the nurse's station. On 4/20/23 she and the DHW met with Staff A again. Staff A said she grabbed pillows as the chair in the nurse's station was not comfortable. She had the door shut and the lights off and was watching a television show on her phone. Staff A said she was not sleeping. The ED said too much time had lapsed from the DHW and ED notification and said staff should call immediately. She said staff should immediately respond to the door alarms. The ED said because of lighting issues and the cameras there were gaps in the video footage reviewed. When observed on 4/19/23 the video footage from 4/15/23 and 4/16/23 in memory care revealed at 12:13 a.m. Staff A came back to the nurse's station with what appeared to be two pillows in her hand. She went into the nurse's station and the door was shut and lights were off. At 12:35 a.m. Tenant #1 (as identified by the Director of Operations) entered in the view of the camera. He was dressed in a long sleeved shirt, pants and did not have his walker. He was observed on video using the railing and the backs of furniture as he walked down the west exit door hallway. At 12:37 a.m. he came back up the hallway and entered another tenant's apartment. The video footage did not show when Tenant #1	A 150	(c) working at all times under the assumption that memory care door alarms are properly functioning (there shall be no assumption that an alarm system is not functioning as intended); and (d) staff response to an alarm. 4. The Executive Director will conduct weekly Quality Assurance meetings with the Director of Health and Wellness and nurses as designated by the Director of Health and Wellness to review and ensure daily pendant response times are appropriate and additional staff education is provided as needed. In addition, the Program has added a Quality Assurance process which will be reviewed at the weekly meetings. The new process will include a verification 3 times per day that the doors are operating properly with one of such tests each day generating a physical report and sounding the alarm.	ongoing

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A 150	Continued From page 9 left the apartment. At 12:52 a.m. the video footage showed the nurse's station door was open but the video footage did not show when Staff A left the nurse's station. At 12:55 a.m. Staff B arrived in the memory care unit and entered through the main entrance door. At 1:33 a.m. Tenant #1 was observed walking in the foyer of the building with Staff A and Staff B on each side of him and Staff C walked behind them. When observed on 4/19/23 at approximately 11:55 a.m. there were four doors in the memory care unit, the main door was attached general population AL, the east exit door, the west exit door and the patio door. During the observation the memory care west exit door was opened, the alarm sounded and a page was received. When observed on 4/20/23 at 5:18 a.m. and 7:40 a.m. there was a sidewalk that went from the memory care west exit door around the building to the front of the building to a small parking lot. Tenant #1 was located in the grass area in front of the parking lot. When traveled by foot from the memory care west exit door to the end of the sidewalk at the parking lot and back to the memory care west exit door was apporoximatley 200 steps. When observed at 5:18 a.m. prior to sunrise, the area was not well lit and the lighting available was mostly from two exterior door lights and lighting from inside the building. The path Tenant #1 traveled was not observed; however, possible terrain included: sidewalks and grass area. The State Climatologist reported the following weather observations from Cedar Rapids on 4/16/23 between 12:30 a.m. and 1:30 a.m. the temperature was 38 degrees, relative humidity was 37%, winds were from the north, northwest	A 150	5. The Community updated its Memory Care Door Alarms Policy and Procedure on June 21, 2023 and all health and wellness staff working subsequent to July 15, 2023 are required to be trained in and knowledgeable about the updated policy and procedure at the beginning of his or her first shift following such if not sooner trained. A copy of the Memory Care Door Alarms Policy and Procedure dated June 21, 2023 is attached as Exhibit D. 6. Pager System Upgrades and Memory Care Door Service and Replacement. On April 17, 2023 the Executive Director learned that one of the memory care door alarms had been reported as malfunctioning on April 12, 2023. The Director of Facilities had checked the door on April 13, 2023 in response to a work order and was unable to recreate a false alarm and then concluded the door operated properly. On April 17, 2023, the Executive Director immediately contacted an employee of Hawkeye Communications for a service call regarding the memory care doors. Prompt measures were then taken to ensure the doors and alarms operated properly including replacement of one of the doors which has been completed as well as an upgraded mag lock security device.	7/15/23 6/30/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 150	Continued From page 10 at 18-24 miles per hour (mph), gusting to 31 to 33 mph and there was some precipitation in the area. There was a wind chill value of 26 to 27 degrees. Record review revealed the door alarm records indicated on 4/16/23 at 12:36 a.m. the memory care west exit door was activated and was not reset for 40 to 50 minutes. Record review of the Program's Memory Care Door Alarms policy and procedure indicated there were four doors and all were alarmed at all times. There were two doors that had a keypad and two doors that were egress doors (including memory care exit door). The handle was pushed for 15 seconds and the door would open and send a page to staff. The door could be disarmed by using a key and would be reset using the key. All staff were responsible for wearing a pager and responding to the door alarms. If a staff observed someone coming or going that set off the alarm, they would announce that memory care was okay and reset the alarm (if needed). If a door alarm went off and it was not witnessed by staff, staff would complete a head count. If all tenants were accounted staff would communicate that via radio to all staff. If a tenant was not located staff would initiate the Missing Persons policy and procedure. Continued record review of the Welcome to the Keystone Cedars Memory Care document indicated staff must respond to every door alarm immediately. If staff did not identify anyone near the door, to complete a head count. If the tenant was unaccounted for to initiated the missing persons/elopement policy and procedure. Further record review of the Program's Missing	A 150	The Community is in the process of updating the job description for the Director of Facilities to ensure that any maintenance requests whatsoever regarding the memory care doors are immediately reported to the Executive Director. The Executive Director has ordered additional sensor upgrades for the east and west doors to ensure the memory care door alarm will be heard throughout the Memory Care. Upgraded sensors have been ordered for the east door and west door of the Memory Care to ensure the alarm system transmits at a higher volume. Although unrelated to series of events, an upgraded transmitter has been ordered to ensure pager notifications show the location of the transmission as opposed to a tone only.	7/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0195	A. BUILDING: _____ B. WING _____	C 04/20/2023

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A 150	Continued From page 11 Persons policy and procedure indicated to notify all staff on duty, start a search of the building and grounds and notify the ED and DHW. If the tenant was not found in the building or on the grounds, to call 911. When interviewed on 4/20/23 at 9:48 a.m. the DHW said the policies and procedures that were not followed related to the elopement included: not responding to the door alarm properly, the AL staff not checking in with memory care staff and no all clear sent and not notifying the DHW sooner.	A 150		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop a service plan that identified the specific needs of the tenant. This pertained to 1 of 1 tenant reviewed (Tenant #1). Finding follows: Record review on 4/19/23 of Tenant #1's file revealed Tenant #1 had a diagnosis of Lewy Body Dementia without behavioral disturbance. He was staged at a five on the Global Deterioration	A 350	Service Plans 1. On June 21, 2023 the Director of Health and Wellness conducted a training session with all nurses on: (a) Proper completion of a Service Plan for residents who have exhibited a tendency to wander; (b) Services which may help with wandering; and (c) Nurse Review Policy dated April, 29, 2022. 2. On April 21, 2023 the Community reviewed the service plans of all residents with a history of elopements and wandering. The Community identified one (1) resident with a history of elopements and wandering. The Community revised the service plan for the identified resident from two-hour safety checks to one-hour safety checks.	6/21/23 4/21/23

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A 350	Continued From page 12	A 350		

Scale (GDS), which indicated moderately severe cognitive decline. The service plan dated 4/11/23 reflected safety checks every two hours, related to wandering,elopement and supervision. The checks indicated to ensure Tenant #1 was safe and to give him water when he was awake. The service plan also indicated to make sure Tenant #1's walker was next to the side of the bed when he slept.

Continued record reivew revealed Tenant #1's elopement incident reports on 10/10/22 at 7:30 p.m. and on 4/16/23 at 12: 36 a.m.

Record review on 4/19/23 of Tenant #1's Incident Report dated 4/16/23 at 12:36 a.m. indicated an elopement occurred with Tenant #1. At 12:00 a.m. a safety check was completed and Tenant #1 slept close to the wall. The memory care west door alarm went off at 12:36 a.m. Staff responded and did not see anyone. Staff was not able to get the door alarm to turn off, she completed a head count and search. It was noted Tenant #1 was missing and staff contacted the medication aide from assisted living to assist. After a search of the outside the Director of Health and Wellness (DHW) was called. Tenant #1 was found outside on the front side of the building. He was kneeling on his left knee in the grass. Tenant #1's vitals included: blood pressure was 114/64, pulse was 70, oxygen saturation was 93%, temperature was 96.9 degrees and respiration rate was 16. It was noted Tenant #1 did not sustain any injuries and walked back to his apartment with two staff. The incident report indicated the primary care provider and family were notified.

Continued record review revealed Tenant #1's service plan was not updated post elopement on

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A 350	Continued From page 13 4/16/23 to reflect Tenant #1 had eloped and any additional safety interventions. The elopement on 4/16/23 was his second elopement; his first elopement occurred on 10/10/22. The service plan reflected to complete two hour safety checks (related to wandering/elopement and supervision); however, did not reflect Tenant #1 had elopements and any further interventions related to his safety. When interviewed on 4/20/23 at 9:48 a.m. the DHW confirmed Tenant #1 had elopements on 10/10/22 and 4/16/23.	A 350		