STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165584	A. BUILDING _____ B. WING _____	12/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1005 LINCOLN AVENUE DUBUQUE, IA 52001

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date: 12/15/2021 JB The following deficiencies relate to the Recertification Survey and Facility Reported Incidents #97322 and #99153 conducted December 6 - 14, 2021. Facility Reported Incident #97322-I was substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	F-000 This plan of correction constitues our written allegation of compliance for the deficiencies cited. However, submission of this plan of corrections is not an admission that a deficiency exits or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to administer medications within professional standards for 1 of 12 residents observed (Resident #24) during medication administration. The facility reported a census of 61. Findings include: Observation during medication pass on 12/7/21 at 12:24 PM, Staff I, Certified Medication Aide, placed Resident #24's medication cup on his/her tray table. The medication cup contained furosemide 40 mg and Dairy Relief 3000 units. Staff I stated she was going to lunch and would	F 658	F658 Staff I and Staff J were re-educated to watch all resident take all of their medication. Staff I was assigned CE Solution education Preventing Medication errors for C.M.A.'s. The Director of Nursing observed staff I give 5 different residents using various routesf and passed 100%.The DON will do random medication observations monthly for three months, review at QAPI meeting quarterly and reassess the need to continue medication surveillance monthly. Nurses were re-educated on the Medication Administration policy including self-administration for residents	12/9/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Susan Westmark	Administrator	1/14/2022

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

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F 658	Continued From page 1 have Staff J check on the resident to make sure she took her medications as she likes to take them with food. Staff I exited Resident #24's room at 12:33 PM and closed the door. Continuous observation showed no one entered Resident #24's room until 12:44 PM. At 12:44 PM, Staff J entered the resident's room with her lunch plate and asked the resident if she took her medications. Resident #24 stated she did take the medication. Staff J, Registered Nurse, stated it is a common practice to leave medications with Resident #24 to take on her own without direct supervision. Step number 16 in the Medication Administration Policy dated 10/1/21 directed staff to observe consumption of medication. During an interview on 12/9/21 at 2:10 PM, Staff D, Director of Nurses, stated she would expect staff to follow all facility policies. She stated she would not expect mediations to be left at bedside.	F 658		
F 689 SS=K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, and staff interview, the facility failed to provide	F 689	F689 Failure to provide adequate assessment and supervision for resident who exited the building at 6:05 and was found by staff at 6:10 am no injuries. It is the practice of this provider to ensure that each resident receives adequate supervision and assistive devices to prevent accidents. Upon investigation of the elopement, it was determined that a C.N.A. helped the resident gather his belongings for his bath and the resident was on the way to the whirlpool rooms as he does each bath day, this day he went on the elevator and exited building. A wanderguard was placed on the resident. In an effort to protect all residents, we placed continuous alarms on our elebator doors on December 8, 2021 which surveyor verified.	12/9/2021

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F 689	Continued From page 2 adequate supervision and failed to implement safety interventions to prevent an elopement for 1 of 12 residents sampled (Resident #43) for supervision. The resident had a history of leaving the unit without staff knowledge. The resident exited the second floor elevator and then exited the ground floor ambulance door without staff knowledge. Staff F found Resident #43 in his pajamas, bath robe, and slippers on the street behind the facility. Resident #43 stated he was lost. The failure resulted in Immediate Jeopardy to the health, safety, and security of the residents. The facility identified 17 residents as independently mobile and cognitively impaired. The facility reported a census of 61. Findings include: The Minimum Data Set (MDS) for Resident #43 dated 6/28/21 documented diagnosis including Cerebrovascular Accident (Stroke), Parkinson's disease, and Type 2 Diabetes Mellitus. The MDS documented a Brief Interview for Mental Status (BIMS) score of 8, indicating cognitive impairment. The MDS documented the resident was independent with ambulation and locomotion around the unit but needed limited assistance of 1 person for locomotion off the unit. The Care Plan revealed Resident #43 had a self-care deficit and moderately impaired cognition related to dementia. The Care Plan revealed Resident #43 independent ambulation with his walker and directed staff to cue, reorient and supervise as needed. A Progress Note dated 7/16/2020 at 2:37 PM, revealed the staff placed a wander guard bracelet Resident #43 due to an incident where he left the	F 689	continue from page 2. Education on the alarms being on continuously was sent out to employees through our communication tool REMIND via text on December 8, 2021. On December 9, 2021 we were notified of an immediate jeopardy related to elopement. To abate the immediate jeopardy, a wandering assessment was performed on all residents. We developed a care plan focus, goal and interventions on all residents scoring >8 on the wandering assessment. In addition, all residents scoring >8 were placed on a list which is posted at all of our nurse's stations and distributed to all departments. The list includes mitigation measures for ensuring safety of wandering residents. The Director of Nursing reviewed all resident's care plans for elopement that were already implemented and utilize a wanderguard. Our Elopement policy and procedures were updated on December 9, 2021 to include all residents receiving a wandering assessment upon admission and at least quarterly with MDS. This policy along with education on elopment risk interventions and residents that are identified at risk for elopement were distributed to all staff employed in our facility via our REMIND communication tool, sent to each employee's email and posted at the time clock for employees to review and sign off on before their next shift. Our Elopement policy already included step for staff to monitor wanderguard bracelets and door alarms to ensure functioning, which was not the situation in the elopement identified as an immediate jeopardy. To ensure ongoing compliance, our interdisciplinary team will meet weekly and utilize the tool "Elopement Risk Assessment" to review all residents determined to be at risk for elopement. These weekly meetings will occur at our weekly therapy meetings,	

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F 689	Continued From page 3 floor. Resident #43 made comments that if his wife wasn't here he would go outside and leave. An Order Note dated 8/20/20 at 5:23 PM, revealed the wander guard discontinued, removed and the staff notified the family. Progress Note dated 8/24/21 documented the resident walked to the nurse's station and when the nurses left the area, the resident got on the elevator and went downstairs and exited the facility. An off going nurse found the resident in the street behind the facility at 6:15 AM. The nurse walked the resident to safety and called the facility to have someone bring a wheel chair down. The resident stated he was confused and had tears in his eyes. A wander guard bracelet was applied. Progress Note written 8/24/21 at 9:00 AM, documented the staff left a voicemail for Resident #43's son to inform him of the incident. Two of the resident's daughters were notified and a condition report was sent to the physician to request an order for the wander guard. Progress Note dated 8/24/21 at 9:54 AM documented the resident had a wander guard placed on 7/8/20 to enhance safety. The resident's family request it be removed as it was upsetting to the resident and unnecessary. The wander guard was removed on 8/20/20. The resident had no wandering episodes prior to 8/24/21. Progress Note dated 8/24/21 at 11:43 AM documented the son wanted the neurologist notified regarding confusion and memory loss.	F 689	Continued from page 3 for one month, longer, concerns are identified. Following the month, the interdisciplinary team will discuss at each therapy meeting to review residents at risk for elopment, meetings are weekly. Staff members were also assigned additional In-service education on CE Solutions which addresses knowing which resident is at risk and what to do if a resident wanders or elopes. We held an in person in-service on January 6, 2021 at 1:30 pm and reviewed the Elopement policy and procedures for assessing wandering risk, interventions to prevent elopements and what to do in the event a resident elopes. Schumacher elevator and Globalcom put a stop on our elevators. The elevator doors will only open if a code is entered. Staff and families educated on the code, and to make sure no residents enter the elevators with them. 1/10/2021 Our facility QAPI/QAA team will review compliance on wandering risk assessments, wanderguards and procedures related to elopement prevention on at least a quarterly basis	12/9/2021

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F 689	Continued From page 4 Progress Note dated 8/24/21 at 2:34 PM documented the resident was placed on the Urinary Tract Infection (UTI) Protocol. His temperature was 97.7 degrees Fahrenheit. Progress Note dated 8/24/21 at 10:20 PM documented no further wandering episodes. Review of the Clinical Record showed there was no documentation of a physical assessment or complete set of vital signs (temperature, heart rate, blood pressure, respirations or oxygen saturation) for the resident. The Clinical Record lacked a wandering assessment for Resident #43. The summary of the incident dated 8/24/21 documented per camera footage the resident got on the elevator and left the floor unattended/unnoticed at 6:00 AM. The resident left the facility through the ambulance door at 6:05 AM. The resident was found in the street behind the facility by a Staff F when leaving after her shift. There was no physical assessment documented. During an interview on 12/8/21 at 12:11 PM, Staff F, Licensed Practical Nurse, stated she left work that morning (8/24/21). While walking to her car she saw the resident in the street. She stated she didn't realize who it was at first but as she got closer she realized it was Resident #43. Resident #43 had on his pajamas, a bath robe and slippers. Resident #43 stated he was lost. Staff F walked Resident #43 out of the street and called the facility to let them know he was outside and to bring a wheelchair. She stated the resident was confused, upset, and had tears in his eyes. He looked like he just didn't know where he was or	F 689		

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F 689	Continued From page 5 where to go. Staff E and Staff H arrived with a wheelchair and assisted Resident #43 to sit in the wheelchair. Staff H pushed him on the sidewalk back into the building. Staff F reported Resident #43's gait unsteady and he had shortness of breath. Staff F reported Resident #43 didn't wander earlier that day. She stated he had some confusion in the past. During an interview on 12/9/21 at 12:53 PM, Staff H, Certified Nurse Aide, stated she took a wheelchair down and brought the resident back into building. She stated when she got outside, the resident was in the street at the curb at the back of the building. She stated Staff F was standing with him. He said he was going to church. She stated Resident #43 was a little confused which was unlike him. A wander guard was put on and a urine sampled collected for evaluation. During an interview on 12/8/21 at 11:39 AM, Staff E, Licensed Practical Nurse, stated she arrived to work at 6:00 AM on 8/24/21. Resident #43 approached the window at the desk during report. He greeted the staff, knew he was going for his bath, had his clothes on his walker and did not seem out of the ordinary. The nurses went to the medication room and then the Staff F left the facility. Staff F called the floor and stated she found Resident #43 at the end of the block. Staff E stated the resident was not known to wander prior to that day. She stated she was not aware of any attempts to leave via elevator before and the resident was not confused prior to that day or prior to exiting. When he returned to the floor, she placed a wander guard for safety. She called son and left a message for him to return call and called the daughter to inform her of the incident.	F 689		

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F 689	Continued From page 6 She called the physician to notify him of incident and got the order for the wander guard. She stated when the resident returned to the floor, she checked vitals and "made sure he was ok." She stated she may not have documented the vitals. When Resident #43 returned to the floor, she stated cognitively he appeared normal. He laughed about it, stating he got confused. During an interview on 2/8/21 at 2:25 PM/21 Staff G, Certified Nurse Aide, stated it was his bath day. Resident #43 wasn't there at his usual. Staff H brought the resident in and stated the resident had been outside. She asked the resident where he was going and he knew he was going to the tub, but stated he got confused. He stated he forgot where he was going and knew had a bath but thought he was going to church. A skin check is a normal routine and part of bathing. The resident had no skin concerns. Staff G stated Staff E told her she needed to walk with Resident #43 to make sure he got where he needed to go. During an interview on 12/8/21 at 2:07 PM, Staff D, Director of Nurses, stated a wander guard was placed on the resident's wrist to prevent reoccurrence. She stated he was assessed for a UTI due to increased confusion. It was out of his norm to leave the floor. He was confused that day and was subsequently treated for UTI. She stated that any residents that have any wandering behaviors are assessed and wander guard if needed to prevent elopement. She stated no additional interventions were in place to protect residents from leaving the floor. She reported high staff levels at the time of the incident, as 1st shift was fully staffed and there were still some 3rd shift staff on site. She stated the resident was independent at the time of the incident and did	F 689		

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F 689	Continued From page 7 not require supervision to go to the bath. She stated he had no previous attempts to leave the facility and the wander guard placed on his wrist in July 2020 was due to a misunderstanding. She stated the family asked him to go down stairs. Staff D stated she did staff interviews at the time of investigation but did not document them. She stated she summarized what was said in the incident summary. She stated the ambulance door is not alarmed, it's a public access door. She stated no wander assessment or elopement assessment was completed on resident before or after his elopement. During an interview on 12/8/21 at 3:12 PM, Staff D stated the cameras are not staffed and are used for look back reference only. During an interview on 12/9/21 at 10:30 AM Staff D stated there was no policy for wander assessments. She stated they just started doing wander assessments a couple months ago. She stated they are done on admission and 72 hours later. She stated wander assessments had not been completed on all residents and were not completed quarterly with the MDS. Facility Policy titled Resident Safety/Elopement last revised on 3/15/21 directed staff to complete a thorough examination upon the resident's return to the building. During an interview on 12/8/21 at 10:15 AM, the Administrator stated the incident had not been reported to the state. According to the State Climatologist email dated 12/8/21 at 1:45 p.m. the weather on 8/24/21	F 689		

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F 689	Continued From page 8 between 5:30 AM and 6:30 AM revealed clear skies, visibility at 10 miles, no precipitation, winds out of the south at 9 miles per hour, and 73 degrees Fahrenheit. According tohttps://www.timeanddate.com/sun/@4854561?month=8&year=2021 sunrise on 8/24/21 was at 6:20 AM. The video obtained on 12/14/21 at 10:25 a.m. revealed a route from Resident #43's room to the location staff found Resident #43. The residential street behind the facility had cars parked on both sides of the street and contained uneven and cracked surfaces throughout the street. The State Agency informed the facility of the Immediate Jeopardy on December 9, 2021 at 1:25 p.m. The Facility removed the Immediate Jeopardy on December 9, 2021 by implementing an alarm on the elevator doors and providing staff educated staff on ensuring alarms on continuously. The scope lowered from "K" to "E" at the time of the survey after ensuring the facility implemented education and their policy and procedure.	F 689		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced	F 805	FF805 Dietary cook and staff were educated to write the food item, consistency and scoop size on the tinfoil that is placed over each pan after it is prepared. Policy updated to include writing food item, consistency and scoop size on the tinfoil that is placed over each pan after it is prepared. F805 The dietician will observe the serving of food to the residents once a month and give a report to the Dietary Supervisor and Administrator, the information will be reviewed quarterly at the Quality Assurance meeting.	12/9/2021

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F 805	Continued From page 9 by: Based on observation, clinical record review, policy review and staff interview the facility incorrectly served ground meat to 2 of 3 residents (Resident #6 and #32) in lieu of the physician ordered pureed ordered diet. The facility reported a census of 61 residents. Findings include: 1. The Minimum Data Set (MDS) assessment, dated 9/13/21, showed Resident #6 had long//short term memory impairment and severely impaired decision making. The resident required extensive assistance with eating. The MDS documented a diagnosis of Alzheimer's Disease, late onset. A Physician Request Form, signed by the Provider on 6/29/21, showed a physician order for a pureed diet. A Care Plan, with a revised goal date of 9/14/21, directed the staff to provide the diet as (physician) ordered. 2. The MDS for Resident #32 showed a Brief Interview for Mental Status (BIMS) score of 4 indicating severe cognitive loss. The resident required supervision and set up for eating a mechanically altered diet (e.g., pureed food, thickened liquids). The MDS listed a diagnosis of esophagitis. A Discharge/Transfer Form, dated 1/12/21, documented to admit the resident to the facility with a physician order for a level 1 dysphagia diet, pureed diet with extra sauce/gravy.	F 805		

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F 805	Continued From page 10 A Care Plan, revised 10/21/21, identified Resident #32 had a swallowing problem related to an esophageal stricture from prior radiation therapy and directed all staff to be informed of the resident's special dietary and safety needs. The Care Plan instructed for the resident to eat in an upright position, eat slowly, chew each bite thoroughly and monitor/document/report as needed any signs or symptoms of dysphagia: pocketing (of food), choking, coughing, drooling, holding food in mouth, several attempts at swallowing, or refusing nectar thickened liquids. The Care Plan directed the resident to have a pureed diet with gravies. A review of the dietary menu for 12/07/21 listed a main entrée for 3 ounces (oz.) of roast beef for the regular diet and one serving for the pureed diet. During an observation on 12/07/21 at 9:29 a.m. Staff A, Cook, measured out 12 oz. (4 servings) of roast beef, placed the meat in a robo, added water and thickening powder to pureed. Staff A measured a total volume of 2.75 cups of pureed meat. Staff A verified the measured volume with the Surveyor. The Dietary Supervisor checked the Pureed Diet Portion Sizes/Scoops Chart and had Staff A write a #8 (4 oz.) scoop size. A review of the Pureed Diet Portion Sizes/Scoops Chart for 4 servings, 2.75 cups showed a scoop size of a #6 scoop (5 1/3 oz). During an observation on 12/07/21 at 11:50 a.m. Staff A checked the temperature of the pan of pureed roast beef which had been placed at the back of the steam table on the left hand side. Staff A confirmed the pan was the pureed roast beef when taking the temperature. Staff A	F 805		

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F 805	Continued From page 11 temped the steam pan of ground roast beef located at the front of the steam table pan. The pans were marked with roast beef and a #8 scoop size written on the foil cover the pans. On 12/07/21 at 12:05 p.m. Staff B, and Staff C, Dietary Aides, took the steam cart up to the second floor to the long-term care. Staff B and C placed serving utensils into the steam pans. A 3 oz. scoop was placed in the pureed roast beef steam pan. Staff B started to plate food at 12:08 p.m. Staff B asked Staff C about the roast beef before plating the first ground roast beef portion. Staff B plated out multiple 3 oz. servings of pureed meat to residents on a ground meat diet. At 12:16 p.m. Staff B placed a #8 scoop of ground meat, pureed tomatoes, mash potatoes and gravy on a plate and staff served out to Resident #32. At 12:17 p.m. Staff B placed a #8 scoop of ground meat, pureed tomatoes, mash potatoes and gravy on a plate and staff served out to Resident #6. At 12: 20 p.m. Staff B and C asked to have the nursing staff call the kitchen as they were out of ground meat. During an observation on 12/07/21 at 12:25 p.m. the Dietary Supervisor brought a pan of ground roast beef to the second floor dining room and looked at the pans on the steam table. The Dietary Supervisor stated to Staff B and C they had served out the pureed roast beef as the ground meat. The ground meat had been served out as the pureed meat. Resident #6 and #32 had also been served the ground roast beef in place of the pureed roast beef. The Dietary Supervisor removed Resident #6 and #32's plates from the tables after prompted by the	F 805		

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	165584	A. BUILDING _____ B. WING _____	12/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1005 LINCOLN AVENUE DUBUQUE, IA 52001

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F 805	Continued From page 12 Surveyor. The Dietary Supervisor informed Staff B and C she would prepare more pureed roast beef. During an observation on 12/07/21 at 12:29 p.m. the Dietary Supervisor measured out four, 3 ounce servings (12 oz. total) of roast beef and pureed with beef juice. The total volume of the mixture measured 2 cups. She compared with the Pureed Diet Portion Sizes/Scoops Chart and stated a #8 scoop should be used. She verbalized it was the same measure as the pureed meat from the morning pureed meat prep. She returned to the second floor dining room. Resident #6 received the correct pureed roast beef consistency and portion at this time. Resident #32 had left the dining room and told staff that she did not want any more food. During an interview on 12/07/21 at 1:12 p.m. the Dietary Supervisor reported she had already talked to staff B and she said they normally write the consistency and the scoop size on the foil on top of the steam pan. That had not been done this time, only the scoop size had been written on the foil. She stated this is the first time this has happened. She thought the pureed and ground meats had a similar consistency, but she would expect the staff to serve out the physician ordered diet. On 12/07/21 at approximately 2:00 p.m. the Dietary Supervisor presented a copy of the pureed food preparation policy and stated the policy does not address writing the food item, consistency and scoop on the top foil, and they should probably add that in the policy. She stated the facility didn't have a policy regarding physician orders and diets.	F 805		

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F 805	Continued From page 13 The Puree Food Preparation Policy with a revised date of 01/10/20 lacked direction to the staff to write the food item, consistency, and the scoop size on the top foil of the pan after food preparation.	F 805		

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
	IA0805	A. BUILDING: _____ B. WING _____	12/14/2021

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N 104	50.7(4) 481- 50.7 (10A,135C) Additional notification 481-50.7 (10A,135C) Additional notification. The director or the director ' s designee shall be notified within 24 hours, or the next business day, by the most expeditious means available (I,II,III): 50.7(4) When a resident elopes from a facility. For the purposes of this subrule, " elopes " means when a resident who has impaired decision-making ability leaves the facility without the knowledge or authorization of staff. This Statute is not met as evidenced by: Based on record review and interviews the facility failed to report an elopement for 1 of 1 residents sampled (Resident #43) for reporting. The facility reported a census of 61. Findings include: Progress Note dated 8/24/21 documented the resident walked to the nurse's station and when the nurses left the area, the resident got on the elevator and went downstairs and exited the facility. An off going nurse found the resident in the street behind the facility at 6:15 AM. The nurse walked the resident to safety and called the facility to have someone bring a wheel chair down. The resident stated he was confused and had tears in his eyes. A wander guard bracelet was applied. Progress Note dated 8/24/21 at 9:00 AM documented a voicemail was left for resident's son to inform him of the incident. Two of the	N 104	N105 Education was given to all staff regarding reportable Incidents and Nursing staff was educated to notify Administrator and Director of Nursing when a reportable incident has occured at Bethany Home. A Laminated Pathway for Reportable Incidents was posted at each nurses station.The Director of Nursing audits all nurses notes and audits the report book Monday - Friday, reviewing Saturday and Sundays report Monday morning. Reportable incidents will be reported to the Iowa Department of Inspections and Appeals within 24 or the next business day.	12/10/2021

DEPARTMENT OF INSPECTIONS AND APPEALS

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N 104	Continued From page 1 resident's daughters were notified and a condition report was sent to the physician to request an order for the wander guard. Progress note dated 8/24/21 at 9:54 AM documented the resident had a wander guard placed on 7/8/20 to enhance safety. The resident's family request it be removed as it was upsetting to the resident and unnecessary. The wander guard was removed on 8/20/20. The resident had no wandering episodes prior to 8/24/21. The summary of the incident dated 8/24/21 documented per camera footage the resident got on the elevator and left the floor unattended/unnoticed at 6:00 AM. The resident left the facility through the ambulance door at 6:05 AM. The resident was found in the street behind the facility by a Staff F when leaving after her shift. During an interview on 12/8/21 at 12:11 PM, Staff F, Licensed Practical Nurse, stated she found the resident when she was leaving work after her shift. She stated she left work that morning (8/24/21) and when she was going to her car she saw the resident in the street. She stated she didn't realize who it was at first but as she got closer she realized it was Resident #43. She stated she approached the resident and he stated he was lost. She walked with him to get him out of the street. She called the facility to let them know he was outside and to bring a wheelchair to get him. She stated the resident was confused and upset. He had tears in his eyes. He looked like he just didn't know where he was or where to go. She stated Staff E and Staff H came out and the resident was assisted to sit in the wheelchair. Staff H pushed him on the sidewalk back into the	N 104		

DEPARTMENT OF INSPECTIONS AND APPEALS

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N 104	Continued From page 2 building. She stated his gait was unsteady and he was kind of short of breath. She stated she didn't know him to wander prior to that day. She stated he has had some confusion in the past. When she found the resident he was wearing his pajamas, a bath robe and slippers. During an interview on 12/8/21 at 10:15 AM, the Administrator stated the incident had not been reported to the State Agency.	N 104		