STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455725	A. Building B. Wing	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Hu	8450 Will Clayton Pkwy Humble, TX 77338

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35963 Based on observations, record review and interviews, the facility failed to ensure an environment that was free of accident hazards and that each resident received adequate supervision to prevent accidents for 3 of 8 residents (R#1, R#2, and R#3) reviewed for accidents The facility failed to prevent Resident#1 from eloping from the facility on 8/20/22. Resident #1 eloped from the facility around 7:30 PM when EMS arrived at the facility. Resident #1 let the EMS personnel into the building and then eloped from the facility. Resident #1 was not found until Monday, August 22 at 10:30 AM, 4 miles from the facility. Resident #1 had crossed a heavily trafficked four-lane street. The facility failed to have a working wander guard system to protect the 3 residents (R#1, R#2, and R#3) who have current physician ordered wander guards due to identified wandering behaviors. An Immediate Jeopardy (IJ) situation was identified on 08/24/2022 at 3:45 PM. While the IJ was removed on 08/28/2022, the facility remained out of compliance at a scope of a isolated with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. The failures placed all residents at risk of unsafe environment without proper supervision. Findings include: Record review of Resident #1's face sheet dated 8/24/22 revealed a [AGE] year-old male, who admitted to the facility on [DATE]. His diagnoses include alcoholic dementia (impaired memory) kidney failure, altered mental status (change in mental function) and metabolic encephalopathy (problem in the brain). Record review of Resident #1's MDS dated [DATE] indicated a BIMS of 5, indicating cognitive impairment. Resident #1 also required limited assistance with ADLS. (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's care plan dated 5/26/22 indicated he had impaired cognition and required assistance from one staff member. Further review of Resident #1's care plan indicated he was an elopement risk and wanderer, had history of attempts to leave facility unattended and impaired safety awareness. Resident #1's interventions included checking placement of wander guard, distract resident from wandering by offering pleasant diversions, activities and television. Record review of Resident #1's elopement risk assessment dated [DATE] read in part, Resident is at risk for elopement due to cognitive status and ability to ambulate. Wander guard place to right ankle. Record review of Resident #1's August 2022 physician orders indicated Resident #1 was to have a wander guard on at all times due to risk of elopement. Further review of physician's orders indicated staff are to monitor the wander guard each shift to ensure proper function. Staff were to be documented 0 if it was not working or alarming. Record review of Resident #1's August 2022 MAR revealed there were 0's in place for wander guard effectiveness on August 10, 11, 12, 13, 14, 16, 17, 19, 20, 22 and 23rd. No documentation indicating any intervention was done. Record review of Resident #1's nursing note dated 8/20/22 written by LVN A read in part, .At approximately [8:15 PM] [Resident #1] was searched for to administer his medication. However, was unable to locate him. In depth search of inside facility as well as perimeter was conducted . Record review of Resident #1's nursing note dated 8/22/22 at 3:30 PM written by LVN A read, Resident has been located, safe and sound. Record review of Resident #1's nursing note dated 8/22/22 at 11 AM written by Administrator read in part, Writer followed up with RP . regarding need for placement to secure unit due to exit seeking behavior. RP acknowledged understanding. RP stated he will presently look for a memory care unit . Writer informed of current plan of care which included [one-to-one] monitoring until alternate placement is found for resident . Record review on 8/23/22 at 1:15 PM of maintenance door checked from 7/11/22 through 8/11/22 indicated each door was working properly. No issues noted. In an interview on 8/23/22 at 10:48 AM with CNA B, she said on 8/20/22 around 7:30 PM she saw Resident #1 standing at the nursing station. She said during that time, the residents were watching TV. She said she had just started working at the facility and was training with another CNA that was assigned to Resident #1. She said during the rounds, unable to recall time, she heard LVN A say they were looking for Resident #1. CNA B said it was about 45 minutes after she had seen him that the nurse said Resident #1 was missing. CNA B did not state she knew if Resident #1 was an elopement risk. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 8/23/22 at 11:03 AM with LVN F, she said she was to check residents pretty frequently on her hall as they often walk around. She said for residents who are elopement risk, they have orders in the computer to check the residents and their wander guard bracelets every shift. She said they have a wand that they will use to check the wander guard bracelets. If the wand lights up green, it is working properly, but if it is red, then it needs to be replaced. She said staff are to notify the DON if the wander guard is not working properly and the DON will provide the staff a new wander guard for the resident. She said they also should be documenting if the bracelet is working or not. LVN F said if a resident elopes staff are to immediately start looking for the resident inside and outside of the building. In an interview on 8/23/22 at 11:20 AM with the Maintenance Director, he said he was to check all doors once a week for the alarm to be working properly and to make sure the wander guard system was working. He said he would document on his maintenance log if the doors passed or failed. He said if it is not alarming properly, he will try to fix it or call out a company to come service the doors. He stated the last time he checked the doors was on 8/18/22 and they were working properly. In an interview on 8/23/22 at 11:27 AM with CNA C she said she was to sit with Resident #1 during her 6AM-2PM shift due to Resident #1s recent elopement. She said if she had to leave for break, she was to notify another staff member to sit with him. In an interview on 8/23/22 at 12:06 PM with the Maintenance Director, he said he got a call on Sunday evening (8/21/22) from the Administrator stating that the wander guard door wasn't working on the 200-hall. He said he came to the facility, checked all doors and they were working properly. He said he called for the fire safety company to come out to check the doors but did not get an answer. He said the company came out on Monday (8/22/22) to check the wander guards/doors and said they did not see anything wrong with them and they were working properly. The Maintenance Director said at the time of checking the doors on Sunday (8/21/22), he was not aware of Resident #1 eloping. He said he was made aware on Monday (8/22/22) that he eloped. In an interview on 8/23/22 at 12:18 PM with CNA D, she said on Saturday (8/20/22), she worked with Resident #1 on 2-10 shift. She said she arrived at 2pm, did her rounds and dinner. She said she took her break around 7PM and she saw Resident #1 walking around the nursing station. She said when she came back around 7:30 PM another resident was going to the hospital, so she went to assist the nurse with getting that resident ready. CNA D said around 8 PM LVN A asked her if she seen Resident #1 because she could not find him. She said she did not hear any alarms going off and she said she has not known for Resident #1 to elope before and he only required minimum supervision. She said Resident #1 has a wander guard but has not attempted to elope before. CNA D said she went outside, went room to room and started yelling his name. She said she checked the emergency exit doors that they were still locked. She said she there were visitors in the facility, but during that time she was not aware of Resident #1 being missing. She said she asked other stations to help look for him as well, but they were unable to locate him. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 8/23/22 at 12:24 PM with LVN A, she was the night nurse for Resident #1 and worked 6pm-6AM on 8/20/22. She said when she arrived, she sat at the nursing station, and she saw Resident #1 walking around in the nursing station and was talking to staff and other residents. She said around 6PM the nurses did shift report and she recalled Resident #1 standing at the desk. She said he was standing at the desk for a while. She said he was talking to the nurses and telling others that he wanted to go home, which was the first time she ever heard him saying that. LVN A said every 15-30 minutes she would scope the area and check each resident to see their location. She said close to 8 PM she was sending another resident out to the hospital and CNA B and CNA D were assisting in the room while EMS was there. She said after she completed that she went to go look for Resident #1 to give him his medication. She said Resident #1 wanders often and you have to be on guard with him. LVN A said when she went back to the cart, she was getting ready to go to Resident #1's room, and when she went to his room, she didn't see him. She said she started going down the hallway and checking for his common areas that he would be at. She said Resident #1 was unable to be located and the staff started looking for him all over the building and some staff went outside. She said after several minutes of not being able to locate him, she called 911 and the Administrator. LVN A said she did not hear any door alarms going off and while her and CNA B and CNA D were in the room assisting another resident, no one was on the hallway monitoring the other residents. In an interview on 8/23/22 at 1:30 PM with the Administrator, she said she was told by LVN A that Resident #1 was last observed at the nursing station by staff around 7:30 PM. She stated during her investigation, she spoke with one of the EMS staff that came to the building and the EMS staff informed her that Resident #1 was at the door and when EMS came in, he went out. She said EMS informed her that she was not aware that Resident #1 was a resident and thought he was a family member of another resident. The Administrator said around 8/:10 PM, LVN A began looking for Resident #1 to administer his medications but was unable to locate him. She said the staff began looking for Resident #1 inside the building and in surrounding areas outside of the facility. She said the police were involved with looking for the resident and she also looked at his last known address for Resident #1 but was unable to locate him. The Administrator said she conducted audits of the doors and wander guard system to ensure they were functioning properly on 8/21/22 and asked the Maintenance Director to come fix the door on 200-hall as it was not locking properly. She stated she was not aware of the door not working properly until she checked it during her rounds. She said Resident #1 was found two days later (Monday, 8/22/22) by the police. She said Resident #1 was taken to the hospital to be assessed before being brought back to the facility and was placed on one-to-one supervision once he arrived at the facility. She stated Resident #1's family members were made aware that he was found and his plan of care was updated to reflect the elopement and will continue to one-to-one until secure placement is found. The Administrator stated staff are to check every day, every shift for the functioning of the wander guard bracelet and to make sure it is on each resident. She said the maintenance director is to check the doors weekly and perform any maintenance that is needed. In an interview on 8/23/22 at 2:11 PM with Resident #1 he said he walked to his old house a couple nights ago because he had to go home. Resident #1 said he left so that he could also go back to work. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 8/23/22 at 2:45 PM with the DON, she said on 8/20/22 she was notified by the Unit Manager that Resident #1 had eloped. She said staff immediately began looking for the resident in the facility and in the community. She said in interviewing LVN A (on 8/20/22), she said she last saw Resident #1 around 7:30 PM. She said LVN A went to go administer Resident #1 medication around 8 PM and was unable to locate him. The DON stated when she arrived at the facility on Saturday night (8/20/22) she checked the wander guard alarms with the wand to ensure they were all working properly, and they were. She said she started educating the staff on Saturday about the elopement policy and re-educated the nurses on how to check the wander guard system. She said if the wander guard was not working or not in place, the staff are to notify her immediately and she will provide them with a replacement. She said upon Resident #1 returning, his wander guard was checked to make sure it was working and it was. The DON said staff should be rounding frequently to ensure the residents are safe and inside the facility. The DON stated she was responsible for training staff on resident elopement and elopement drills. In an interview on 8/23/22 at 3:30 PM with community partner, they said around 6:30 AM on Monday (8/22/22), Resident #1 was sitting down on the ground by their office. He stated Resident #1 was not able to get up by himself and was scooting himself on the ground trying to get into the building. The community partner stated he assisted Resident #1 up and into a chair in the office. He stated Resident #1 was visibly confused and kept repeating himself, which prompted him to call 911. The community partner stated he was not aware that Resident #1 was missing from nursing facility. An attempt was made various times during survey to speak with EMS personnel regarding Resident #1. Call was not returned prior to survey exit. Observation on 8/23/22 at 10:00 AM of the front entrance of the facility revealed a busy four-laned street. There were four highly trafficked lanes going parallel to the facility. Observation on 8/23/22 at 11:30 AM of Resident #1 sleeping in bed. CNA C was sitting with him. Observation on 8/23/22 at 1:07 PM of door by alarm by 100-hall being tested by the Maintenance Director revealed the door alarm was not working. Wander guard was brought to the door and right on alarm system and no sound was noted. Wander guard was waved at the door and past the wander guard alarm and no alarm was heard. Observation on 8/23/22 at 1:10 PM of 200-hall door, zone one, door was tested with wander guard alarm. When wander guard was waved at the door and walked through the door with wander guard, the door alarm did not go off. Resident #2 Record review of Resident #2s face sheet dated 8/23/22 revealed an [AGE] year-old male, who admitted to the facility on [DATE]. His diagnosis included Alzheimer's disease, chronic obstructive pulmonary disease (damaged airway of the lungs) and hypertension (high blood pressure). Record review of Resident #2's MDS dated [DATE] indicated a BIMS of 10, indicating mild cognitive impairment. Resident #2 also required limited assistance with ADLS from one staff. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #2's care plan dated 6/3/22 indicated he had impaired cognition and required assistance from one staff member. Further review of Resident #2's care plan indicated he was an elopement risk and wanderer with impaired safety awareness. Resident #2's interventions included checking placement of wander guard and monitor for effectiveness of wander guard. Record review of Resident #2's August 2022 physician orders indicated an order written dated 4/8/22 indicating Resident #2 was to have a wander guard on at all times due to risk of elopement. Further review of physician's orders indicated staff are to monitor the wander guard each shift to ensure proper function. Staff were to be documented 0 if it was not working or alarming. Record review of Resident #2's August 2022 MAR revealed there were 0's in place for wander guard effectiveness on August 1, 3, 4,5,6,8,10, 15, 17, 21 and 22nd. The 0's were placed by several nurses working with Resident #2. No documentation indicated any follow up was done to address the wander guards not working properly. Record review of Resident #2's nursing note dated 6/11/22 written by LVN F read, Staff reported that resident went past alarm and wander guard did not alarm. This nurse checked wander guard that is on resident left ankle with wander guard device and current wander guard on resident left ankle is functioning good . [sic] Observation on 8/23/22 at 2:07 PM of Resident #2 being to the door by CNA E to test the door alarm on 200-hall. The door alarm did not go off when Resident #2 went through the door, wearing a wander guard bracelet. When the resident was brought back into the facility, the door alarm did not go off. Resident #3 Record review of Resident #3's face sheet dated 8/23/2022 revealed a [AGE] year-old-male, who admitted to the facility on [DATE]. His diagnosis included dementia, hypertension (high blood pressure), gait abnormality and chronic fatigue (extreme tiredness). Record review of Resident #3's MDS dated [DATE] indicated a BIMS of 8, indicating mild cognitive impairment. Resident #3 also required limited assistance with ADLS from one staff. Record review of Resident #3's August 2022 physician orders indicated an order written dated 6/28/22 indicating Resident #3 was to have a wander guard on at all times due to risk of elopement. Further review of physician's orders indicated staff are to monitor the wander guard each shift to ensure proper function. Staff were to be documented 0 if it was not working or alarming. Record review of Resident #3's August 2022 MAR revealed there were 0's in place for wander guard effectiveness on August 2, 4, 5, 6, 8, 10 and 21, 2022. The 0's were placed by several nurses working with Resident #3. No documentation indicated any follow up was done to address the wander guards not working properly. Observation on 8/23/22 at 1:14 PM of Resident #3 at the 200-hall door with wander guard bracelet on. Door alarm not sounding. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation and interview on 8/23/22 at 2:00 PM with the Administrator, she tested the door alarms and said it is supposed to sound when a resident goes through the doors with a wander guard bracelet on. Resident #3 was used as a demonstration and when the staff took him through the door, wearing wander guard bracelet, the alarm did not go off. The Administrator said the door alarm should go off when residents go through the door. She said each shift the nurses are to check for the wander guard to be working and for the bracelet to be placed on the residents. In an interview on 8/23/22 at 2:05 PM with CNA E, she said the wander guard alarms goes off when residents are sitting too close to the door. She said sometimes when staff are leaving the shift and Resident #3 is sitting too close to the door, the alarm will go off. CNA E said the nurses are to check the wander guards and if the CNAs notice the bracelet is not on a resident, they are to notify the nurse immediately to have it replaced. The Administrator was notified of the Immediate Jeopardy on 8/24/22 at 3:45 PM and the IJ template was provided. The Plan of Removal was accepted on 8/26/22 at 2:28 PM and included the following: 8-24-2022 Immediate Action: Actions taken to immediately ensure there were no other residents in jeopardy or threat of harm included assuring all other residents were present and accounted for on the night of 8/20/22. The Administrator and Director of Nursing Services searched each resident room and common area in the center. Additional audits included medical record reviews and observations by the Director of Nursing Services and Director of Clinical Operations of all residents identified at risk for elopement to assure proper placement and function of wander guards with up-to-date care plans. No negative findings resulted from the audit. The audit was completed on 8-20-2022 by the Director of Nursing Services and Director of Clinical Operations. Resident # 1 was successfully located and returned to the center after being assessed in theER on [DATE]. Nursing staff completed a full body assessment upon his return to the center. His care plan was reviewed and updated to include his recent exit seeking behavior. Upon his return, we placed him on 1:1 monitoring until such time that we can assure that he is no longer actively exit seeking. Staff will redirect from exit doors as needed. Patterns of wandering will be monitored. An activity referral was initiated to enhance participation and diversion. An update photo was taken and placed in the elopement book. A care plan conference was conducted with the Responsible Party (RP) regarding need for alternate placement in a secured unit. The center is currently seeking alternate placement. Until alternate placement is secured, the resident will remain on 1:1. The RP and center staff were updated on the changes in the care plan on 8/22/22. On 8/20/22, an immediate investigation was initiated by the administrator to determine how the resident was able to get outside. 8/20/22- the Director of Nursing Services and Director of Clinical Operations audited the elopement books to assure pictures and care plans were up to date to assure inclusion of all at risk residents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Centers plan to ensure compliance quickly included: On 8/20/2022- All exits doors and windows were audited by the Administrator. All doors where noted to be secured and functioning properly. On 8-20-2022, an order was placed by the administrator for additional door alarms that enunciate louder. These alarms are scheduled for arrival and instillation by the maintenance director on 8-25-2022. 8/20/22, Elopement policies and procedures were reviewed by the center leadership including the Administrator, Director of Nursing and Director of Clinical Operations. On 8-20-2022, education was initiated by Director of Nursing Services for staff on Elopement guidelines, abuse and neglect prevention, responding to alarms timely with conducting immediate search of grounds and center. The education will be completed by 8-23-2022. Any staff that has not received education by this date will not be allowed to work prior to education. On 8 -22-2022, The Total Fire and Safety Company arrived at the center to perform a complete check of the exit doors and alarms. Documentation was provided to support the proper function of the doors. 8/22/22-Signage was placed on the doors by the Administrator to instruct visitors and others to notify nursing staff prior to allowing residents to exit the building unsupervised. 8/22/2022- the Maintenance Director will check doors daily to assure proper working order. The door checks will consist of checking the functionality of the door alarms with the wander guard alarm wand and include checking the locking mechanism. The documentation of the door checks will be completed by the Maintenance Director and monitored by the Administrator. 8-22-2022, a focused QAPI meeting addressing the findings and corrective action was initiated and completed. The attendance of the Administrator, Director of Nursing, Regional [NAME] President, Director of Clinical Operations, Medical Director, MDS and Social Services. 8-24-2022, team member(s) will monitor the door 24/7 with a designated staff member to ensure that no one is able to leave without our knowledge. This will continue until new alarms are installed and functioning properly. The monitoring of the door will be captured by the staff member and monitored by the Administrator. 8-24-2022, education continues by the Director of Nursing for staff to include how the wander guard system functions, answering alarms immediately, who to report elopement events t, reporting timelines and need to immediately report a nonfunctioning alarm. Nursing staff will audit placement and function of wander guards daily. The education included identifying and recognizing s/s of resident with the potential of elopement such as verbally expressing wanting to leave the facility, anxious behaviors, restlessness, frequent observations of resident by doorways The education will be documented and monitored for compliance by the Administrator. Additionally, the staff were educated to report exit seeking or escalating behaviors to the Director of Nurses and Administrator. The training will be complete by 08/25/22. Any staff member not trained before this date will be educated prior to working. New staff will be educated in new hire orientation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The medical record documentation of the functionality of the wander guards was reviewed. The documentation requirements were clarified to accurately reflect the proper function of the wander guard system for all 3 residents. This documentation will be reviewed by the DNS starting 08/24/22. Director of Nursing or designee will conduct Elopement drills on different shifts every week times 4 weeks to ensure proper procedure. Elopement drills were started on 08/23/22. These drill will assure staff responds to the alarms promptly and efficiently. Drill findings will be presented in QAPI monthly for a minimum of 3 months. Any negative findings will be corrected immediately. Maintenance and or designee will check doors and alarms daily times 4 weeks to ensure they are functioning properly. Functionality of the doors were started on 08/20/22. Findings will be addressed in QAPI monthly for a minimum of 3 months. Any negative findings will be corrected immediately. 8/25/22- Total Fire arrived to enhance the enunciation of the door alarms down the middle hall so that it can be heard at the nurse station. Door screechers will be installed by the Maintenance Director upon their arrival on 8/25/22. The administrator will monitor and assure 100% compliance with attendance and participation with education. Surveyor Monitored the Plan of Removal as follows: Observations were started on 8/26/22 at 3:00 PM and continued through 8/28/22 at 3:30 PM. Resident #1 was observed at various times and shifts with a one-on-one sitters CNA C, CNA D, CNA H and CNA M. No concerns with supervision noted. Resident #1 appears to be in bed and sleeping on and off throughout the day. All staff documented every 30 minutes what Resident #1 was doing during three shifts. Observations made on 8/26/22 through 8/28/22 at various times of the wander guard doors being tested and were sounding when residents wearing wander guard bracelets were close to the door and when the wander guard went through the doors. The door alarm volume was increased, and all staff responded to door alarm when it rung. Record review of Resident #1's nursing notes revealed nursing staff documenting and also monitoring Resident #1. No issues were observed. Interviews were started on 8/26/22 at 3:00 PM and continued through 8/28/22 at 3:30 PM with staff across all three shifts, including weekdays and weekends. That staff interviewed regarding the plan of removal: LVN A, CNA B, CNA C, CNA D, CNA E, LVN F, CNA G, CNA H, LVN I, CMA J, LVN K, CNA L, CNA M, LVN N, LVN O, Receptionist P, Receptionist Q, Laundry, Social Service Director, Housekeeping, Maintenance, Administrator, Director of Nursing, Assisted Director of Nursing and Unit Manager. All staff interviewed verbalized adequate understanding of plan of removal training received regarding elopement risk and protocol, wander guard documentation, recognizing elopement behaviors, wander guard system, immediately responding to door alarms, location of elopement binders and abuse and neglect. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455725	A. Building B. Wing	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Hu	8450 Will Clayton Pkwy Humble, TX 77338

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In interviews started on 8/26/22 at 3:00 PM and continued through 8/28/22 at 3:30 PM with ADON, LVN A, LVN F, LVN I, LVN N and LVN O, all stated they have been in-serviced on documenting the effectiveness of Resident #1, Resident #2 and Resident #3's wander guard bracelet. All nurses stated if the wander guard is not working properly, they are to immediately notify the DON and also get a replacement. An extra wander guard bracelet is kept at each nurse's cart to be accessed if the DON is not in the building. In an interview on 8/29/22 at 11:13 AM with the Administrator and the DON, both stated this situation occurred due to someone letting a resident out that they thought looked like a family member. The Administrator stated they have in-serviced staff on elopement protocol and placed signs at the exit doors notifying visitors to not let anyone out of the building. They both stated the alarms have been increased to notify all staff when the door is opened. The DON said she is glad Resident #1 returned safely because the facility is in front of a highly trafficked street and he could have possibly been hit by a car. The DON stated Resident #1 will be discharged to with family on 9/1/22. Record review of the POR binder revealed: A binder kept at each nursing station that showed the residents who are elopement risks, how to place wander guard bracelet and wander guard policy. Signs were placed at all exit doors to instruct visitors and others to notify nursing staff prior to allowing residents to exit the building unsupervised. In-services conducted were Elopement policy and guidelines, abuse and neglect prevention, responding to alarms timely with conducting immediate search of grounds and center. The education was be completed on 8-23-2022. On 8/25/22 in-services were conducted on how the wander guard system functions, answering alarms immediately, who to report elopement events to, reporting timelines and need to immediately report a nonfunctioning alarm. Nursing staff will audit placement and function of wander guards daily. The education included identifying and recognizing signs and symptoms of resident with the potential of elopement such as verbally expressing wanting to leave the facility, anxious behaviors, restlessness, frequent observations of resident by doorways. The staff were educated to report exit seeking or escalating behaviors to the Director of Nurses and Administrator. The facility conducted elopement drills starting 8/23/22 and will continue on weekly. Maintenance will continue to monitor the functioning of the doors and the wander guard system. The fire safety company came to enhance the door alarms to ring down the hallway so it can be heard at the nurses' stations. Policies reviewed were Elopement Policy dated April 2017 and Abuse and Neglect policy dated January 2019. While the IJ was removed 08/28/22 at 3:30 PM and the Administrator was notified, the facility remained out of compliance at a severity level of actual harm at a scope of pattern due to the need to complete in-service training and evaluate the effectiveness of the corrective systems.