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| N 000 | Initial Comments<br><br>On 03/28/2024 with additional information gathered through 05/14/2024, Surveyor conducted a complaint and facility self-report investigation. As a result one deficiency was identified.<br><br>The complaint was substantiated.<br><br>Census: 14 | N 000 | | |
| N 426 | 83.38(1)(b) Supervision.<br><br>As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Supervision. The CBRF shall provide supervision appropriate to the resident's needs.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review and interviews, the provider did not provide supervision appropriate to the resident needs to prevent elopement for 1 of 1 resident.<br><br>Resident 1 was cognitively impaired with poor decision-making skills and had a history of elopement. On 02/06/2024 Resident 1 eloped from the Assisted Care sister facility (16th Street South) unnoticed and was returned by the LPD (Local Police Department). On 02/07/2024, Resident 1 was moved from the Assisted Care | N 426 | | |

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

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sister facility to the Memory Care facility (12th Street South) to ensure Resident 1's safety. Sometime after 10:15 PM on 02/07/2024, Resident 1 left the Memory Care facility unnoticed and was located by the LPD at 1:48 AM. The provider did not ensure Resident 1 received adequate supervision, which resulted in Resident 1 being able to leave the facility on 02/07/2024 unsupervised for over three hours. As a result, Resident 1 was cold and sustained a skin tear to his/her left wrist and knee. Additionally, following the elopement Resident 1 experienced a change of condition and passed away five days later while receiving hospice services.

This requirement is being cited for the third time. See statements of deficiency (SOD) L26R11, dated 05/26/2021 and SOD ZV7X11, dated 01/15/2019.

Findings Include:

The facility has been licensed since 02/01/2011 as a Class CNA (non-ambulatory) facility which serves residents who are ambulatory, non-ambulatory, or semi-ambulatory, but one or more of whom are not physically or mentally capable of responding to a fire alarm by exiting the CBRF without help or verbal or physical prompting. The facility is licensed to care for 20 residents with programming for residents including irreversible dementia, Alzheimer's disease, and advanced age.

The provider's policy titled Resident Elopement, revised 05/10/2016, indicated, "The principal mission of KSMS Our House is to provide supportive services that enable older adults to prolong their ability to live in a safe and dignified living environment. To ensure that residents are

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safe at KSMS Our House, many locations are equipped with wandering systems to ensure that team members are aware of when residents, team members, and visitors to the building are entering and leaving the building ...Any situation in which a resident who is determined to be incapacitated or under guardianship and his/her whereabouts are unknown, attempts to leave the building unattended, or leaves the building unattended is considered an elopement. All residents upon admission are to be assessed using the Risk of Elopement Review to determine if the resident is an elopement risk. The director should review residents risk due to confusion or impaired judgment, as well as history and potential for risk of elopement. The determination of the risk of elopement must be addressed in the residents ISP. If a resident is considered an elopement risk, the ISP must address appropriate steps to ensure that the resident is safe at all times such as appropriate and adequate staffing is available, availability of alarms, appropriate ways to prevent elopement of resident, as well as steps to take if resident attempts to leave or has left the building unattended. Residents who are at risk of elopement are to be placed in Memory Care locations to ensure appropriate and adequate staffing is available at all times to meet the safety needs of the resident ...Residents who are at risk of elopement may never live in an Assisted Care location due to the reduced staffing and lack of monitoring systems for elopements ..."

On 02/09/2024, the provider submitted a self-report to the department. The report indicated, [Resident 1] was admitted to the Memory Care location on 02/07/2024 and ambulated independently with no device. [Resident 1] was assessed using the Risk of

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Elopement Review and was considered an elopement risk. Interventions were for team members to immediately answer door alarms, one team member in commons at all times, and to encourage resident to spend time in common area. On 02/08/2024 at approximately 1 AM, [Former RCA (Resident Care Assistant)-B] was completing rounds and entered [Resident 1's] room and noted [Resident 1] was not in [his/her] room. [Former RCA-B] notified [Former RCA-C] that [Resident 1] was not in [his/her] room, and they completed a search and head count of the location and were unable to locate [Resident 1]. [Former RCA-C] notified [AD (Assistant Director)-A] at 1:14 AM. [AD-A] arrived at the facility at 1:25 AM. [AD-A] searched the building including resident rooms, closets, maintenance room and laundry room. [AD-A] checked all egress doors, and they were locked and functioning. At 1:28 AM, [AD-A] notified [ED (Executive Director)-D] of [Resident 1's] elopement. [ED-D] instructed [AD-A] to call 911 and [Resident 1's family]. The LPD located the resident a block away from the facility, sitting on a curb and returned with [Resident 1] at 1:58 AM. [AD-A] and [Former RCA-C] assisted [Resident 1] out of the police car, into a wheelchair and brought the resident back into the building. [AD-A] indicated [Resident 1] transferred with one assist and had no complaints of pain when assisted out of the police vehicle. Once in the building, [AD-A] got [Resident 1] a blanket and wrapped the blanket around the resident and noticed [Resident 1's] left hand was bleeding and told [Former RCA-C] to clean and bandage the open area. Hospice was contacted and arrived to assess [Resident 1]. [AD-A] and [ED-D] did a walk-through of the building to try to figure out how [Resident 1] got out of the building. All windows were checked, and egress doors

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checked again. Each egress door was working, and each window was secure. [Former RCA-C] asked [Resident 1] what happened, and [Resident 1] stated [s/he] walked out the wood door behind someone. The front exit door is wood with glass windows. [RCA-E] left the building out the front door at 11:15 PM. [Resident 1] had been last seen at 10:15 PM in bed watching TV and wearing a gray short sleeved T-shirt and sweatpants. The self-report indicated, [Resident 1] was not on any required checks prior to this incident. Following the incident, the facility placed [Resident 1] on half hour checks and placed an alarm on [Resident 1's] room door. Staff were retrained on when entering or leaving the building to ensure the delayed egress doors were shut, latched and reset.

On 03/28/2024, Surveyor viewed the LPD video footage. The footage showed Resident 1 was located by the LPD on 02/08/2024 at 1:48 AM. Resident 1 was sitting on the side of a paved road, in an upright position with his/her legs stretched out in front of him/her, wearing a short sleeve shirt, jogging pants and hard sole slippers. Resident 1 had a cut to his/her left arm. Additionally, the police footage revealed Resident 1 denied being hurt or in need of an ambulance. Resident 1 stated s/he "was cold." Resident 1 was able to stand and sit in the back of the police vehicle with the assistance of police officers. The LPD returned Resident 1 back to the facility at 1:57 AM.

According to www.wunderground.com the outside temperature in Wisconsin Rapids on 02/08/2024 at 1:15 AM, 1:35 AM and 1:55 AM was 37 degrees Fahrenheit.

On 03/28/2024, Surveyor toured the facility and

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reviewed the floor map. Surveyor noted the facility had a total of three exits (a front door, a west back exit door near room 8 and an east back exit door near Room 17) that lead directly outside. Surveyor observed all three exit doors were equipped with delayed egress doors. (Delayed egress doors are used to alert staff with an audible alarm if a resident is attempting to leave and designed to delay the resident from exiting for 15 seconds. The alarm is silenced when a code is entered on the keypad located on the wall next to the door.) Surveyor had AD-A demonstrate the use and testing procedure for all three delayed egress doors. Surveyor observed all three delayed egress doors were working properly and all door alarms sounded when activated. Additionally, Surveyor observed a sign on the front door that read, "Please make sure the door is closed and reset when entering or leaving the building."

On 03/28/2024, Surveyor reviewed the closed medical record for Resident 1. Resident 1 was admitted from the providers Assisted Care sister facility on 02/07/2024 with diagnoses to include lung cancer and dementia. The record indicated Resident 1 had an APOA (Activated Power of Attorney) and was receiving hospice services.

A "Risk of Elopement/Wandering Review" report for Resident 1, dated 02/07/2024 indicated, the resident was at risk for elopement/wandering. Additionally, the report indicated the resident was cognitively impaired with poor decision-making skills and had a history of elopement.

A "New Resident Introduction" form for Resident 1, dated 02/07/2024 indicated, "This form is used to orient staff to new resident...Before Coming to Our House resident lived at 16th Street Assisted

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Care...Please assist with: ...Wandering ...Other Special Needs/Interest: [Resident 1] gets up in the middle of the night and wanders."

A "Behavioral Assessment" form for Resident 1, dated 02/07/2024 indicated, "This assessment is to be completed on all referrals being assessed for placement..." The assessment included a list of questions to which a check mark was identified to show "YES" and "NO" answers. The following was noted:

*Anxiety: 1. Does the person become very nervous or worried easily? A Yes answer was checked in response to the question with a handwritten note "Wants to go home, looking for car."

*Wandering/Elopement: 1. Does the person pace or wander in the house. A Yes answer was checked in response to the question. 2. Does the person attempt to leave the house unattended. A Yes answer was checked in response to the question. How often does the behavior occur? A handwritten note, "Once at home, once at 16th Street." 3. Does the person try to leave the house not dressed appropriately for the weather? A Yes answer was checked in response to the question. 4. Does the person seem unable to sit still and needs to keep moving? A Yes answer was checked in response to the question. How often does the behavior occur? A handwritten note, "At night."

*Sleep Behaviors: 1. Does the person have any difficulties sleeping? A Yes answer was checked in response to the question with a handwritten note, "Up at Night." 2. Does the person awaken you during the night. A Yes answer was checked in response to the question with a handwritten

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note, "Reverse Sleep." ...5. Does the person get up in the middle of the night and think it is a different time of the day? A Yes Answer was checked in response to the question..."

A "Resident Incident Report" for Resident 1 indicated, "Date of Incident: 02/08/2024, Time: 1:15 AM...Type of Incident: Elopement...Location of Incident: OUTSIDE OF COMMUNITY: Off Grounds What did the resident tell you about what happened? That [s/he] walked out the front door the one with wood around it. Describe what you saw and heard (just the facts): Went in to check on resident and [s/he] was gone building searched, staff walked around perimeter of building. Were there witnesses? No. Were there apparent injuries? Yes: Skin Tear: left wrist and left knee. Vital Signs: B/P: 150/95, Pulse: 73, Temp: 96.9, Resp.: 18. What did you do? Describe all the assistance given. Called on call searched for resident and called hospice. 911 called and Police arrived and went to look for resident. Resident was found on 14th and Grove sitting on the curb by Faith Baptist church." Surveyor noted the report indicated Resident 1's family and Hospice were notified. The report also included an incident investigation which indicated, "Was there previous history of this type of incidents? Yes: eloped from the assisted care house. Was a reduction plan in place? Yes: Medication changes from hospice, team to answer door alarms immediately. Contributing Factors: Environmental Factors- None. Contributing Factors: Resident Factors- Impaired Mental Status, Impaired Safety Judgement...Resident Follow Up and Prevention: Environmental Modifications-Alarm on resident room door..."

On 03/28/2024 at 9:40 AM, Surveyor interviewed

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AD- A. AD-A indicated the provider had multiple facilities located throughout Wisconsin with two locations in Wisconsin Rapids. AD-A stated, "The 16th street location is strictly assisted care, with no secured doors and this location, 12th street is memory care which has secured doors." AD-A indicated the facility utilizes Eldermark Senior Living Software (an EHR-electronic health record) for resident progress notes, incident reports, ISPs (Individual Service Plans) and other documentation. AD-A confirmed Eldermark is used at both locations and when a resident transfers between the two facilities (12th and 16th street), staff can access and view resident information on any resident who resides at either location in the EHR. Surveyor then asked AD-A about Resident 1. AD-A stated, "[Resident 1] walked independently, had confusion, and wanted to go home. [Resident 1] came to us from our 16th street location on 02/07/2024 because [s/he] eloped. The 16th street location doesn't have secure exit doors and we do." AD-A went on to say, "I was working the day [Resident 1] arrived from the 16th street location on 02/07/2024. When I left at 5 PM, [Resident 1's] family was here visiting. I told [Resident 1's family] staff would be doing safety checks every hour during the night shift. Then at 1 AM, I received a call from [Former RCA-C] telling me [Resident 1] was not in the building. I got here in 5 minutes and did a complete building search, with no luck. I called 911, [ED-D] and [Resident 1's family]. The LPD came and ask questions and went out looking for [Resident 1]. Fifteen minutes later the LPD called me and said [Resident 1] was found about a block away, and asked if I would meet them in the parking lot with a wheelchair...[Resident 1] was able to get into the wheelchair without any concerns and I brought [him/her] into the building. Once in the building I got [Resident 1] blankets

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and wrapped them around [him/her] because [s/he] was cold and it was cold outside that night...[ED-D] and I were here until about 5 AM. When I left [Resident 1] appeared comfortable and the Hospice Nurse was aware." Surveyor then asked if hourly safety checks were documented for Resident 1. AD-A verified hourly safety checks were not documented, but AD-A's expectations were for staff to complete hourly safety checks throughout the night on Resident 1. AD-A went on to say, "Staff were trained to complete a walk through with the oncoming and off going shifts to ensure all residents are accounted for and their needs are met." AD-A verified on 02/07/2024 a walk through was not completed at 11 PM between the PM shift and Night shift. AD-A indicated, all staff working the PM shift and Night shift on 02/07/2024 received a "Corrective Action" for failing to complete the 11 PM walk through. AD-A stated, "[Former RCA-B] and [Former RCA-C] did not complete the 12 AM safety check on [Resident 1], because [Resident 1] was not reported missing until 1 AM and nothing was documented." AD-A indicated, following Resident 1's elopement, the Night shift staff denied hearing any door alarms go off during their shift on 02/07/2024. Night shift staff reported they were in the common areas of the building throughout the shift and did not hear any alarms or see anyone leave. [Resident 1] reported [s/he] followed someone down the hall and out the front door. When I talked to [RCA-E] and [RCA-F] who worked the PM shift on 02/07/2024 they both denied seeing anyone leave behind them when they left. I've been told different stories...Either [Resident 1] walked out an exit door behind staff when staff deactivated the alarm to leave, or staff did not respond to a door alarm."

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| N 426 | Continued From page 10<br><br>On 03/28/2024 at 11 AM, Surveyor reviewed the "Corrective Action" forms for Former RCA-B and Former RCA-C. Both forms indicated the following, "On 02/07/2024, [Former RCA-B] and [Former RCA-C] failed to complete rounds at 11 PM when arriving on shift. A resident had eloped from the building, and the resident was only checked on at 1 AM, at which point the resident had been outside for a significant amount of time. RCAs need to know the whereabouts of all residents and ensure rounds are completed as required..."<br><br>On 03/28/2024 at 11:15 AM, Surveyor asked AD-A if Resident 1 had an ISP. AD-A provided Surveyor with an ISP for Resident 1 with a start date of 02/05/2024. The ISP indicated, the resident required cueing for grooming and ambulation, and assistance of one staff for bathing and dressing. Additionally, the ISP indicated, "Wandering: Wanders inside facility (common area only) Resident will wander inside of building but is easily redirected. On 02/06/2024, Resident eloped out of building on 16th street and was brought back by police officer at 6:20 AM...02/07/2024, resident is transferring today to memory house per family request." AD-A indicated, the 02/05/2024 ISP start date was the date Resident 1 moved into the 16th street location. AD-A confirmed the ISP dated 02/05/2024 was in place and utilized when Resident 1 was admitted to the facility on 02/07/2024. AD-A stated, "When [Resident 1] moved from 16th street, we continued using [Resident 1's] ISP dated 02/05/2024 and made updates when needed..."<br><br>On 04/10/2024, Surveyor reviewed Resident 1's Progress Notes which revealed the following: | N 426 | | |

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| N 426 | Continued From page 11<br>*02/07/2024 at 10:04 PM- "Stayed in [his/her] room for first few hours of this shift came out for dinner ate but wasn't happy about the soup...Went to living room with another resident who started to try to get staff to open door so they could leave staff had other resident go do something else. [Resident 1] laid on couch after meds. Staff got [him/her] to [his/her] room, cares done, talked to [him/her] for a while no problems."<br><br>*02/08/2024 at 4:09 AM- "Staff please make sure you check every half hour and chart ASAP. Resident eloped, was found and hospice came...We need to make sure doors are closed completely especially front door. Resident has been in room since 2:15 AM with [family]."<br><br>*02/08/2024 at 2:40 PM- "Resident has had a very hard time transferring throughout shift...received a new hospital bed and wheelchair."<br><br>*02/09/2024 at 4:29 AM- "...When staff was trying to get resident to stand [s/he] was having a hard time so it took 2 staff members, but it was still hard but did get resident up so we could get [him/her] in bed better to change [him/her]..."<br><br>*02/09/2024 at 10:49 PM- "...Resident has been in bed for the entire shift but was toileted and washed up."<br><br>*02/11/2024 at 9:27 PM- "...Resident's family was here during dinner and resident ate a little of [his/her] dinner."<br><br>*02/12/2024 at 1:53 PM- "Laid in bed all day and didn't eat lunch."<br><br>*02/13/2024 at 10:54 AM- "Resident passed this | N 426 | | |

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| N 426 | Continued From page 12<br>morning hospice notified at 10:18 AM."<br><br>On 04/10/2024, Surveyor reviewed Resident 1's Hospice notes which revealed the following:<br><br>*02/07/2024 at 12:04 PM- "[Resident 1] is independent in walking and transfers. Writer received a phone call this morning informing writer [Resident 1] will be moving to 12th street due to dementia, confusion, and behaviors... [Resident 1] ate 100% of lunch. [Resident 1] in a good mood...[Resident 1] denies pain...Family transferred [Resident 1] to 12th street and writer met them there...Writer spoke with [AD-A] at the facility and updated [her/him] on history of resident, concerns and behaviors..."<br><br>*02/08/2024 at 4:10 AM- " ...Writer notified of resident wandering from facility. Unsure how long resident was in outside elements. Found by LPD about a block from facility. [Former RCA-C] believes [Resident 1] exited the building behind 2 employees exiting...Left wrist and left knee abrasions...Left knee is stiff due to fall, but [Resident 1] is able to stand from lift chair with assist of two..."<br><br>*02/08/2024 at 7:21 PM- " ...Writer was informed that resident eloped from facility at an unknown time but thinking it was at shift change at 11 PM. Staff were not aware of [Resident 1] leaving facility until 1 AM...Resident has no memory of fall or eloping from facility...Family is upset and very worried this is going to happen again as this is the second time in 3 days...Writer has ordered two alarms (bed and chair). Facility will be putting window stops on room window. Door alarm on resident room door. Facility will do education on closing doors and monitoring that door is closed before walking away..." | N 426 | | |

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| N 426 | Continued From page 13<br><br>*02/11/2024 at 10:54 AM- "Transfer: Bed bound."<br><br>*02/13/2024 at 10:31 AM- "...Writer was contacted by the facility that [Resident 1] has passed away..."<br><br>On 03/28/2024 at 2:00 PM, Surveyor interviewed RCA-F regarding Resident 1. RCA-F stated, "I was working the PM shift on 02/07/2024, which was the first day [Resident 1] was admitted. During the PM shift [Resident 1] didn't know where [s/he] was or why [s/he] was living here. [Resident 1] asked everyone to get [him/her] out of here and to find [his/her] car. [Resident 1] was telling staff [s/he] wants to get out to get [his/her] car. Another resident was showing [Resident 1] the keypad next to the front door and how [Resident 1] would need a code to get out. I was able to redirect both residents away from the door. [Resident 1] later fell asleep on the couch in the common area. Sometime around 9 PM I asked [Resident 1] if [s/he] wanted to get ready for bed. [Resident 1] walked down to [his/her] bedroom very slowly and I helped [him/her] to bed. I went in [Resident 1's] room at 10 PM and [s/he] was sleeping. At 10:40 PM, Night shift staff arrived [Former RCA-B] and [Former RCA-C]. [Former RCA-B] asked me who [Resident 1] was, and I told [Former RCA-B] that [Resident 1] came from 16th street because [s/he] eloped and [Resident 1] was wanting to leave throughout my shift." RCA-F went on to say, "I walked out the front door at the end of my shift...I didn't see any residents near the door and didn't see any residents leave behind me."<br><br>On 03/28/2024 at 3:00 PM, Surveyor interviewed RCA-E regarding Resident 1. RCA-E indicated Resident 1 was confused, independent with | N 426 | | |

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cares, transfers and ambulation. RCA-E stated, "I worked the PM shift on 02/07/2024. When I arrived, I was told by AM shift [Resident 1] moved from 16th street over to us because [Resident 1] escaped and [s/he] needed a more secure building. On 02/07/2024, during the PM shift [Resident 1] ate dinner, socialized, and watched another resident mess around with the front door by pushing buttons on the keypad. I redirected the other resident away from the door. Around 9 PM [Resident 1] went to bed. The last time I checked on [Resident 1] was at 10:20 PM. At that time [Resident 1] was awake in [his/her] bed watching TV. When Night shift staff arrived [Former RCA-B and Former RCA-C], I pulled up [Resident 1's] computer notes from the 16th street location. I left the notes up on the computer screen for [Former RCA-B] and [Former RCA-C] to read and told them "You need to keep your eyes on [Resident 1] because [s/he] eloped while at 16th street and staff over there were doing frequent checks on [him/her]."
RCA-E went on to say, "I left around 11:10 PM and went out the front door. No residents walked out behind me, and I made sure the front door was completely shut...I have no idea how [Resident 1] got out. I was written up because management said they couldn't pinpoint what exact time [Resident 1] left the building. When [Resident 1] was reported missing, I received a call from management asking what [Resident 1] was wearing because the Night shift staff didn't know. If Night shift staff would've been doing hourly checks, they should've known what [Resident 1] was wearing." Surveyor then questioned RCA-E how [Resident 1] was after the 02/07/2024 elopement incident. RCA-E stated, "The first day [Resident 1] was here [s/he] was up walking around on [his/her] own. After the elopement [Resident 1] changed. [Resident 1]

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was unable to get out of the recliner chair or bed because [s/he] had a lot of knee pain. It took three staff to get [him/her] out of the recliner. [Resident 1] was placed on bed rest, given comfort meds and was eating on and off."

On 04/01/2024 at 11:40 AM, Surveyor interviewed Former RCA-C regarding Resident 1. Former RCA-C verified [s/he] worked the Night shift on 02/07/2024 and stated, "When I arrived, I was told by PM shift [Resident 1] was a new resident. I didn't know anything about [Resident 1] because I didn't have time to read all the notes on the computer about [him/her]...[Former RCA-B] was responsible for doing hourly rounds on [Resident 1]. [Former RCA-B] notified me at 1 AM [Resident 1] was missing." Former RCA-C verified [s/he] nor [Former RCA-B] checked on [Resident 1] until 1 AM on 02/08/2024. Former RCA-C stated, "I should've double checked on [Resident 1], that way we would've been able to determine when and how [s/he] got out of the building..."

On 04/01/2024 at 1:15 PM, Surveyor interviewed Hospice RN (Registered Nurse)-G regarding Resident 1. Hospice RN-G stated, "Before the 02/07/2024 elopement [Resident 1] was up walking around. After the elopement [Resident 1's] left knee was very painful and swollen, [s/he] couldn't put any pressure on the left leg and [s/he] couldn't stand. The pain in [Resident 1's] knee was bad, [s/he] became combative and was not [him/herself]...[Resident 1] went downhill quickly after the elopement."

***Surveyor noted Resident 1 experienced a change of condition following the 02/07/2024 elopement. Resident 1's ISP on 02/07/2024 noted the resident required cueing for grooming

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and ambulation, and assistance of one staff for bathing and dressing. On 02/09/2024, Resident 1's ISP was updated due to a decline in multiple activities of daily living. The ISP changes indicated the resident utilized a wheelchair, required two staff for transfers, toileting, dressing and grooming.

On 05/14/2024, Surveyor received a Wood County Coroner's Report for Resident 1 dated 02/13/2024, which indicated, "...Manner of Death- Accidental ...How incident occurred- Subject walked away from care facility and was found by law enforcement with signs of having fallen prior to being found...[Hospice RN-G] advised [Resident 1] was on hospice for cancer but also sustained a fall on 02/08/2024 that may have contributed to [his/her] death. [Hospice RN-G] reported [Resident 1] would become agitated and restless since the fall and [s/he] would have to administer Morphine and Lorazepam to get [Resident 1] to relax and sleep. Given this information, I responded to the facility to conduct a manner and cause of death investigation...EXAMINATION OF [Resident 1]: ... [Resident 1] had signs of previously healed cuts and abrasions to [his/her] left knee, left hand, and left wrist, these areas of injury were scabbed over and in the healing process. The examination revealed no obvious signs of fracture or further injury...[Hospice RN-G] reported [Resident 1] was originally housed at the Assisted Living facility located at 16th Street. [Resident 1] had walked away from that facility and was found by law enforcement who returned [him/her] to the facility. [Hospice RN-G] reported [Resident 1] showed no signs of injury and was acting like [s/he] normally does. [Resident 1] was moved to their 12th Street location as that was a memory care facility that has controlled access doors. On 02/08/2024,

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| N 426 | Continued From page 17<br><br>[Resident 1] was found missing by facility staff...Law enforcement found [Resident 1] sitting on the curb in front of the Faith Baptist Church...Law enforcement returned [Resident 1] to the 12th Street facility at approximately 0100 hours on 02/08/2024. It was noted [Resident 1] had injuries to [his/her] left knee and left wrist and was documented in [his/her] resident care records. [Hospice RN-G] reported increased agitation and restlessness after returning to the facility and was continuous up to the day of [his/her] death. [Hospice RN-G] reported having to administer Morphine and Lorazepam to help [Resident 1] rest and calm down. [Hospice RN-G] stated [Resident 1] did not display the agitation and restlessness prior to walking away from the facility on 02/08/2024...[Family Member H] reported [Resident 1] was not able to bear weight on [his/her] left leg, difficulty in speaking, and confused. [Family Member H] elaborated by stating [Resident 1] was having trouble finding [his/her] words and [s/he] was not able to recognize family members [Resident 1] normally recognized immediately. [Family Member H] stated this started on the morning of 02/08/2024, and gradually got worse. [Family Member H] stated this was a complete change from how [Resident 1] was prior to walking away from the facility the second time. [Family Member H] reported having a discussion with facility staff about having [Resident 1] evaluated at the hospital but they declined to have [him/her] transported...CONCLUSION: [Resident 1] was on hospice due to a diagnosis of adenocarcinoma of the lung, malignant melanoma, and multiple myeloma. [Resident 1] was also diagnosed with cognitive impairment. In lieu of these diagnosis' it is apparent that [Resident 1] had sustained a fall consistent with the injuries found on [his/her] left knee, wrist, and hand. Combined with the | N 426 | | |

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| N 426 | Continued From page 18<br>marked decline and the presentation of [his/her] injuries noted after [his/her] return on the morning of 02/08/2024, and in the absence of a medical evaluation to determine the extent of [Resident 1's] injuries, it would appear [Resident 1] sustained a fall that contributed to the cause of [his/her] death."<br><br>In conclusion, the provider did not ensure Resident 1 received adequate supervision, which resulted in Resident 1 being able to leave the facility on 02/07/2024 unsupervised for over three hours. As a result, Resident 1 was cold and sustained a skin tear to his/her left wrist and knee. Additionally, following the elopement Resident 1 experienced a change of condition and passed away five days later while receiving hospice services. | N 426 | | |