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Healthcare Licensing and Surveys

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FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF006	A. BUILDING: _____ B. WING _____	C 12/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN WIND ASSISTED LIVING COMMUNITY	4010 NORTH COLLEGE DRIVE CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	OPENING COMMENTS Rules and Regulations utilized for this survey are: Rules and Regulations for Program Administration of Assisted Living Facilities, Chapter 12, effective 08/24/2020. Rules and Regulations for Licensure of Assisted Living Facilities, Chapter 4, effective 06/28/2001. A complaint survey was conducted by Healthcare Licensing and Surveys on 12/26/23. The survey was prompted by complaint intake LIC-24-016. The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide MA-C- Medication Aide-Certified Nurse Aide LPN- Licensed Practical Nurse Less commonly used abbreviations will be annotated in each deficiency.	S 000		
S5004	Ch 12 Sec 6 (e) Personnel and Staffing Requirements (e) Personnel Policies and Records. (i) Management shall provide new employee orientation and education regarding resident rights, evacuation, and emergency procedures, as well as training and supervision designed to improve resident care. (ii) A record for the manager and each employee shall be maintained and contain at a minimum, the following information: (A) Name, current address and	S5004		

Accepted POC 2/5/24 @ 10:34AM. Chasnee notified. DOC ~~2/16/24~~ 2/24/24 JSappenbergRN

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S5004	Continued From page 1 telephone number; (B) Social Security Number; (C) Education; (D) Work experience, documentation of reference checks; (E) Date of employment; (F) Position in the assisted living facility (job description); (G) Documentation of tuberculin testing; (H) Orientation checklist; (I) I-9, (Employment Eligibility Verification); (J) W-4, (Employee's Withholding Allowance Certificate); (K) Licensure, Certification, or Credentials; (e.g., RN, LPN, CNA, etc.); (L) Documentation of all completed background and Central Registry background check with no offenses. This State Rule and Regulation is not met as evidenced by: Based on staff interviews, personnel record review, emergency procedure drill log review, and facility policy review, the facility failed to provide education regarding emergency procedures related to resident elopement procedures or finding missing residents for 5 of 5 staff members sampled (CNA #1, CNA #2, CNA #3, MA-C #1,	S5004	The Executive Director (ED) and Business Office Director (BOD) will provide appropriate and adequate training to all staff for elopements and all other emergency procedures. Elopement drills will be given x1 per month for 6 months, then quarterly x2. Then elopement drills will be on a semi-annual basis per state regulations. Elopement drills will be executed as described above with first drill being completed 1/24/2024. An additional module for elopement will be added in the new hire orientation by the RNR (Recruitment & Retention)specialist. An audit will be done by the ED/BOD for all current staff and will be completed in a timely manner. The Executive Director and the Environmental Services Director (ESD) will ensure correct and appropriate documentation for the elopement drill is signed by each employee and filled appropriately into employee files showing participation in elopement drills and training with utilization of Edgewood Elopement and Fire policies. Audits will be completed monthly x3 with quarterly x1 for all employee files on drills by ED/BOD/ESD. All corrections, audits and trainings will be monitored by the Quality Assurance System going forward quarterly and a copy will be kept as a record by the ED.	Initial drill completed 1/24/2024 F\U drill dates as described

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S5004	Continued From page 2 LPN #2). The findings were: Interview with CNA #1 on 12/26/23 at 9:30 AM revealed she had been employed at the facility for 7 years and recalled being involved in 2 missing resident drills during her tenure. Interview with LPN #1 on 12/26/23 at 11:53 AM revealed she was working the evening of 12/21/23 when it was identified a facility resident's whereabouts were unknown. She verified she had not been trained by the facility regarding emergency procedures for a missing resident prior to the incident. She revealed she knew what to do from a previous employer and lead the initial missing resident search conducted on 12/21/23. Interview with the executive director on 12/26/23 at 3:20 PM revealed the facility relied on an education software system to prompt the staff month to month to complete their "annual training" requirements. The executive director verified there was no evidence of elopement or missing person drills conducted in the past year. Review of the personnel file for CNA #2 showed no evidence she had received education related to resident elopement procedures or finding missing residents. Review of personnel file for CNA #3 showed no evidence she had received education related to resident elopement procedures or finding missing residents. Review of personnel file for MA-C #1 showed no evidence she had received education related to resident elopement procedures or finding missing residents.	S5004	CNA #1- ED reviewed Elopement drill policy and activation procedures, reporting procedures and sat one-on-one with the staff to ensure understanding was met and clarified any questions and completed by 01/02/2024. CNA #2- ED reviewed Elopement drill policy and activation procedures, reporting procedures and all emergency procedures. ED sat one-on-one with the staff to ensure understanding was met and clarified any questions and was completed on 01/05/2024. CNA #3- ED reviewed Elopement drill policy and activation procedures, reporting procedures and all emergency procedures. ED sat one-on-one with the staff to ensure understanding was met and clarified any questions and completed on 01/02/2024. MA # 1 - ED reviewed Elopement drill policy and activation procedures, reporting procedures and all emergency procedures. ED sat one-on-one with the staff to ensure understanding was met and clarified any questions and completed on 01/05/2024.	

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S5004	Continued From page 3 Review of the emergency procedure drills for the last 12 months showed documentation of two elopements on 4/12/23 and 10/9/23 with no evidence a drill had been conducted before or since the elopements. Review of the facility's policy "Elopement Risk Prevention/Missing Resident" dated February 2023 showed, "The Community strives to promote resident safety and protect the rights and dignity of the residents. The Community maintains a process to assess all residents for risk for elopement..." the policy included procedures for evaluation, prevention, intervention, documentation, elopement drills and education. Elopement drills are to be conducted "on a regular basis, (at a minimum semi-annually" and "utilize the results for staff education."	S5004	LPN #1 ED reviewed Elopement drill policy and activation procedures, reporting procedures and all emergency procedures. ED sat one-on-one with the staff to ensure understanding was met and clarified any questions and completed on 01/05/2024. All corrections, audits and trainings records will be kept by the ED in the Quality Assurance System and regular drills will be performed by the ED/BOD. All emergency protocols will be reviewed by the ED/BOD duringg the scheduled monthly all staff meeting.	
S5014	Ch 12 Sec 7 (c) Assisted Living Facility (ALF) Core Services (c) Resident Rights. The facility shall adopt and follow a written policy of resident rights. The policy shall be posted in a conspicuous place, and there shall be documentation in the resident's record that the resident read, or management explained, the policy. This policy shall not exclude, take precedence over, or in any way abrogate the legal and constitutional rights enjoyed by all adult citizens and shall include, but is not limited to the following: (i) Be treated with respect and dignity; (ii) Privacy; (iii) Free from physical or chemical restraints	S5014	The facility will continue to hold monthly RSA meetings. The facility scheduled, Prevention of Elder Abuse and Resident Rights trainings to be completed by 2/16/2024. These trainings were done on 01/26/2024 and 1/30/2024. The rest of the staff who have not met the scheduled trainings will have a one-on-one meeting with ED to complete these trainings as soon as possible and by 2/16/2024. These records of audit will be kept in individual employee files with BOD.	2/16/2024

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S5014	Continued From page 4 not required to treat the resident's medical symptoms. No chemical or physical restraints will be used except by order of a physician; (iv) Not to be isolated or kept apart from other resident's (v) Not to be physically, psychologically, sexually, or verbally abused, humiliated, intimidated, or punished. (vi) Live free from involuntary confinement or financial exploitation; (vii) Full use of the facility's common areas; (viii) Voice grievances and recommend changes in policies and services; (ix) Communicate privately, including, but not limited to, communicating by mail or telephone with anyone; (x) Reasonable use of the telephone, which includes access to operator assistance for placing collect telephone calls; (xi) Have visitors, including the right to privacy during such visits; (xii) Make visits outside the facility. The facility manager and the resident shall share responsibility for communicating with respect to scheduling such visits; (xiii) Make decisions and choices in the management of personal affairs, assistance plans, funds, or property;	S5014	ED/BOD will review Relias logs to ensure all staff complete annual Resident Rights related competencies. Corporate reviews are scheduled every three months. All employee files will be audited by ED and BOD for all trainings and education for completion and up to date, monthly x3 and then quarterly. The facility will provide the Dementia Care Program Training. This is a mandatory 4 hour training course for all staff members. This will ensure all staff are properly trained to care for all residents with Dementia and Alzheimer's. All trainings will be assigned by 2/24/24 and completed in a timely manner. These trainings will take place quarterly going forward to ensure that all current and new staff continue to stay up to date with all required trainings. RNR Specialist created new employee onboarding checklist to included these trainings and start implementing this checklist since 1/1/2024.	

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S5014	Continued From page 5 (A) Including choice of home health agencies, pharmacies, personal care providers and any other private pay provider. (xiv) Except the cooperation of the provider in achieving the maximum degree of benefit from those services which are made available by the facility; (xv) Exercise choice in attending and participating in religious activities; (xvi) Reimbursed at an appropriate rate for work performed on the premises for the benefit of the operator, staff, or other residents, in accordance with the resident's assistance plan; (xvii) Informed by the facility thirty (30) days in advance of changes in services or charges; (xviii) Have advocates visit, including members of community organizations whose purpose include rendering assistance to the residents; (xix) Wear clothing of choice unless otherwise indicated in the resident's plan, and in accordance with reasonable dress code; (xx) Participate in social activities, in accordance with the assistance plan; and (xxi) Examine survey results. This State Rule and Regulation is not met as evidenced by: Based on observation, resident record review, and staff interview the facility failed to ensure	S5014		

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S5014	Continued From page 6 residents' right to be free from abuse for 2 of 2 sample residents (#5, #7). The findings were: 1. Review of the medical record for resident #7 showed the resident moved into the memory care unit on 12/20/23 with a diagnosis of cognitive impairment.The following concerns were identified: a. Observation of resident #7 on 12/26/23 at 2:10 PM showed the resident was seated in the common area and a bruise was noted under the resident's left eye. 2. Interview with MA-C #1 on 12/26/23 at 10:40 AM revealed on 12/21/23 at 5:45 PM she saw resident #5 and #7 "punching, hitting, and shoving each other and they were separated immediately." Neither resident could provide information about what provoked the incident. 3. Interview with the executive director on 12/26/23 at 2:18 PM confirmed the incident between resident #5 and #7 on 12/21/23 had occurred and revealed the incident had not been investigated or reported.	S5014		
S5020	Ch 12 Sec 7 (e) Assisted Living Facility (ALF) Core Services (e) Resident Records and Reports. Each resident's records shall be current, organized and maintained in individual folders which shall be made available to the resident, the Licensing Division, or designated representative upon request. (i) Each folder shall include the following: (A) Information from the referring agent,	S5020	The facility has provided additional training regarding incident reporting and investigations to all staff to include CNA #1, CNA #2, CNA #3, MA-C #1, LPN #1 and LPN #2.	1/15/2024

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S5020	Continued From page 7 if applicable; (B) History and physical performed by a physician or physician extender; (C) Individual admission form. This form shall, at a minimum, contain the following information: (I) Full name of resident and former address; (II) Date of admission; (III) Sex, race, date of birth, social security number, and former occupation; (IV) Name, home address, and telephone number of relative, fr [redacted] (V) Name, address, and telephone number of resident's personal physician, dentist, ophthalmologist or optometrist; (VI) Medicare number or other medical insurance identifying data; (VII) A written inventory of all personal possessions; however, this inventory need not include personal clothing; (D) All accidents, injuries, incidents, illnesses, and allegations of abuse, neglect or exploitation shall be reported to the resident's family or responsible party and be documented in the individual resident records. All such occurrences shall also be reported to the appropriate entity for follow up and resolution.	S5020		

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S5020	Continued From page 8 Reports of all incidents affecting the health, welfare of safety of a resident shall be provided to the Licensing Division immediately (within one business day). Reporting shall be done by telephone or fax. The facility's investigation of the incident shall be reported to the Licensing Division and the Long Term Care Ombudsman within five (5) working days. Documentation to support the facility reporting the situation and follow up must also be present in the resident records; (E) An accounting of all personal funds deposited with and disbursed by the facility; (I) Upon written authorization of a client, the facility must hold, safeguard, manage and account for the personal funds of the client. (1.) The facility must deposit any personal funds in the excess of $100 in an interest bearing account. (2.) The facility must establish and maintain a system that assures a full and complete and separate accounting according to generally accepted accounting principles of each resident's personal funds entrusted to the facility. (3.) Upon the death of a resident with personal funds deposited with the facility, the facility must convey, within 30 days, the resident's funds a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. (4.) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made	S5020		

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S5020	Continued From page 9 under Medicaid of Medicare except for applicable deductible and coinsurance amounts. (F) A signed copy of the resident's rights; (G) The resident's assessment and individualized assistance plan; (H) Copies of al applicable resident assistance contracts, signed by both parties; (I) Written acknowledgment of the receipt and explanation of all facility policies including admission/discharge policies; (J) Copy of all ALF 102's; and (K) Copy of outside contractual responsibilities, if applicable. (ii) The resident shall be assured of confidential treatment of all information in the record, and the resident's written consent (or the consent of the guardian) shall be required for the release of information to persons not otherwise authorized for receive it. (iii) All residents' records shall be retained in a physically secure area for a minimum of six (6) years after the resident has left the facility and may be disposed of, by shredding or burning, after that time. (iv) In the event of dissolution of the facility, the manager shall notify the Licensing Division as to the location of all residents' records. (v) All records shall be protected from damage by fire, water and other hazards.	S5020		

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S5020	Continued From page 10 (vi) All entries in each resident's record shall be made in ink, signed and dated. This State Rule and Regulation is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to report an incident as required for 2 of 2 sample residents (#5, #7) involved in a resident to resident altercation. The findings were: 1. Review of the medical record for resident #7 showed the resident moved into the memory care unit on 12/20/23 with a diagnosis of cognitive impairment. The following concerns were identified: a. Observation of resident #7 on 12/26/23 at 2:10 PM showed the resident was seated in the common area with a bruise noted under the resident's left eye. 2. Interview with MA-C #1 on 12/26/23 at 10:40 AM revealed on 12/21/23 at 5:45 PM she saw resident #5 and #7 "punching, hitting, and shoving each other and they were separated immediately." Neither resident could provide information about what provoked the incident. 3. Interview with the executive director on 12/26/23 at 2:18 PM confirmed the incident between resident #5 and #7 on 12/21/23 had occurred and revealed the incident had not been investigated or reported.	S5020	The LPNs and the ED have been reviewing incidents daily and at a weekly cadence. All incidents are being reported to the state website on every business day and during this time, the ED is ensuring that the Edgewood protocols are being met. Edgewood has a quality assurance platform that ensures the protocols are being reviewed on a case by case and this review is being done once a week by the ED. ED is in the process of training lead night LPN to review incidents and to ensure incident reporting is complete. All pertinent incidents (hospital transfer and residents at risk for elopement) are reviewed with the clinical staff by the ED on a weekly cadence.	
S5054	Ch 12 Sec 10 (a)(iii) Secure Dementia Units	S5054		

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S5054	Continued From page 11 (a) (iii) Level 2 Direct Care Staff. In addition to meeting all other requirements for direct care staff stated in this Chapter, assisted living Level 2 direct care staff must receive additional documented training in: (A) The facility or units philosophy and approaches to providing care and supervision or persons with severe cognitive impairments; (B) The skills necessary to care for, intervene, and direct residents who are unable to independently perform activities of daily living; (C) Techniques for minimizing challenging behaviors; (I) Wandering; (II) Hallucinations, illusions, and delusions; and (III) Impairments of senses; (D) Therapeutic programming to support the highest level of residents function including: (I) Large motor activity; (II) Small motor activity; (III) Appropriate level cognitive tasks; and (IV) Social/emotional stimulation; (E) Promoting residents dignity, independence, individuality, privacy, and choice;	S5054	The facility is going to provide extensive elopement training; how to identify an elopement, how to report an elopement, when it is appropriate to do an incident report and the elopement building processed. Currently holding weekly clinical staff meeting to address process improvement steps with the LPNs and ED. Clinical staff will assess each resident upon admission, 30 day follow up and annual renewals to determine frequency of safety checks necessary. With each resident receiving safety checks at a minimum of every 2 hours in memory care. Safety checks are currently logged in R-Task and a safety check binder that is housed in each unit. The Executive Director will audit safety check logs weekly x4, monthly x2 and quarterly. Discussing with the Environmental Service Director and the Regional directors for window alarm and the possibility of installing them and the potential pros and cons for it. Environmental Services department did change and fix the window for resident #7. CMS completed Annual Life Code Safety Survey 1/29/2024 with ED.	1/31/2024

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S5054	Continued From page 12 (F) Identifying and alleviating safety risks to residents; (G) Recognizing common side effects and reactions to medications; (H) Techniques for dealing with bowel and bladder aberrant behavior. (I) At least one staff member with this specialized training must be available on the unit at all times to provide supervision and care to the residents, as well as to assist the residents in evacuation of the facility. (J) Staff must have at least twelve (12) hours of continuing education annually related to care of persons with dementia. This State Rule and Regulation is not met as evidenced by: Based on medical record review, staff interview, personnel file review, facility emergency drill review, and policy review, the facility failed to ensure direct care staff training to identify and alleviate safety risks for 5 of 7 sample residents (#1, #2, #5, #6, #7). The findings were: 1. Review of the medical record for resident #6 showed the resident moved into the memory care unit on 12/21/23 due to "memory issues" and required 30 minute safety checks around the clock. The following concerns were identified: a. Review of the safety check log for 12/21/23 showed the resident was last checked on at 5:30 PM and there were no additional checks documented. b. Review of a nurse's note dated 12/21/23 at 8:56 PM showed an elopement of this resident had occurred sometime after 5:30 PM. The	S5054	Reviewed in all staff meeting to ensure this is being done. ED printed enough copies of the form. Educated LPNs and Lead MA to have these forms ready by the first of each month. ED/ BOD will review these forms weekly.	

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	ALF006	A. BUILDING: _____ B. WING _____	C 12/26/2023

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S5054	Continued From page 13 review showed "at 6:48 PM the CNA went to do room checks after report and noticed that the resident was missing..." The ED was called at 7:06 PM about the missing resident and she called 911 at 7:20 PM to report the resident missing. Further review showed "...Cheyenne police department had arrived at around 7:27 PM to notify the staff that a pedestrian had been struck by a truck...Police officer was able to make a positive identification based off of our description...Resident was transported to CRMC for further evaluation..." c. Interview with MA-C #1 on 12/26/23 at 10:30 AM revealed she was on duty when resident #6 eloped from the facility. She reported the resident had moved in earlier in the day from another facility because of exit seeking behaviors and she last observed the resident at about 5:15 PM during the evening meal. She revealed it was reported to her, the resident was not accounted for, at 6:38 PM. She revealed at 5:55 PM she had observed an open window with the screen pushed out in another resident's room, but did not know at that time, resident #6 was not accounted for. She revealed she called maintenance about 6 PM as the window was lifted above the track and slid over the stop block designed to limit the opening and staff could not close it without assistance. d. Interview with LPN #1 on 12/26/23 at 11:53 AM confirmed she was working the evening of 12/21/23 and she had not been trained by the facility regarding emergency procedures for a missing resident prior to the incident. She revealed she knew what to do from a previous employer and lead the initial missing resident search conducted on 12/21/23, both interior and exterior of the building. The LPN revealed while she was outside the facility, she saw lights and sirens going north. At that time, the LPN and	S5054		

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S5054	Continued From page 14 another staff member approached an EMS worker and were able to confirm that a man matching the description of resident #6 had been involved in a pedestrian versus motor vehicle accident and would be transported for emergency care. e. Interview with the executive director on 12/26/23 at 2:14 PM regarding resident #6 confirmed she did not know what time the resident eloped on 12/21/23 but acknowledged the last safety check was outside of the 30 minute requirement. She further revealed she had been notified of the missing resident, by staff, around 7 PM on 12/21/23. f. Review of the personnel file for MA-C #1 showed no evidence she had received education related to resident elopement procedures or finding missing residents. 2. Review of the medical record for resident #2 showed the resident moved into the facility's memory care unit on 2/24/23 with a diagnosis of dementia and required 30 minute safety checks around the clock. The following concerns were identified: a. Interview with CNA #2 on 12/26/23 at 10 AM revealed on 12/25/23, she had clocked out and was waiting for a ride at approximately 2:30 PM in the east parking lot, when she observed resident #2 exiting from the east door of the memory care unit. She revealed she escorted the resident back to the memory care unit and did not report the breech. She revealed she was unsure why staff did not hear the alarm and respond to it; however, she revealed if staff were in rooms on the west hall, they may not hear the door alarm on the east hall. b. Review of the safety check log for resident #2 for the month of December showed on the afternoon of 12/25/23 the resident was last	S5054		

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S5054	Continued From page 15 checked on at 1:30 PM and the next documented check was at 3 PM. There were no checks performed for 1 hour and 30 minutes, during which time the resident was found outside by CNA #2. Further review of the log showed on 12/3/23 the resident was checked at 5:30 AM and was not checked again until 7 AM. On 12/7/23 the resident was checked at 5:30 AM and was not checked again until 7 AM. On 12/10/23 the resident was checked at 5:30 AM and was not checked again until 7 AM. On 12/11/23 the resident was checked at 5:30 AM and was not checked again until 7 AM. On 12/13/23 the resident was checked at 5:30 AM and not checked again until 7 AM. On 12/13/23 the resident was checked at 5:30 AM and and not checked again until 2 PM. On 12/14/23 the resident was checked at 5:30 AM and and not checked again until 7 AM. On 12/15/23 the resident was checked at 5:30 AM and not checked again until 7 AM. On 12/18/23 the resident was checked at 5:30 AM and and not checked again until 7 AM. On 12/23/23 the resident was checked at 5:30 AM and and was not checked again until 10 AM. On 12/24/23 the resident was checked at 5:30 AM and not checked again until 7 AM. c. Interview with CNA #3 on 12/26/23 at 1:33 PM revealed she had been on duty on 12/25/23; however, she was unaware resident #2 had exited the building and was escorted back by CNA #2. d. Review of personnel file for CNA #3 showed no evidence she had received education related to resident elopement procedures or finding missing residents. e. Review of the personnel file for CNA #2 showed no evidence she had received education related to resident elopement procedures or finding missing residents.	S5054	ED educated all staff on each unit the importance of proper documentation and educated clinical staff in ensuring timely charting. Educated clinical staff to alert supervisors when forms are running low or unable to complete charting. ED and lead night LPN will review charting binder on a weekly cadence.	

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S5054	Continued From page 16 e. Interview with the executive director on 12/26/23 at 2:18 PM confirmed she was not aware that resident #2 had exited the building on 12/25/23 until it was reported to her on 12/26/23. She confirmed it should have been reported to her immediately after the incident. 3. Review of the medical record for resident #5 showed the resident moved into the facility's memory care unit on 6/7/23 and required 30 minute safety checks around the clock. The following concerns were identified: a. Review of the safety check log for the month of December showed on 12/3/23 the resident was checked at 5:30 AM and not checked again until 7 AM. On 12/7/23 the resident was checked at 5:30 AM and not checked again until 7 AM. On 12/10/23 the resident was checked at 5:30 AM and not checked again until 7 AM. On 12/11/23 the resident was checked at 5:30 AM and not checked again until 7 AM. On 12/13/23the resident was checked at 5:30 AM and not checked again until 2 PM. On 12/14/23 the resident was checked at 5:30 AM and not checked again until 7 AM. On 12/15/23 the resident was checked at 5:30 AM and not checked again until 7 AM. On 12/18/23 the resident was checked at 5:30 AM and not checked again until 7 AM. On 12/23/23 the resident was checked at 5:30 AM and not checked again until 7 AM. On 12/24/23 the resident was checked at 5:30 AM and not checked again until 7 AM. On 12/25/23 the resident was checked at 5:30 AM and not checked again until 7 AM. 4. Review of the medical record for resident #7 showed the resident moved into the memory care unit on 12/20/23 with a diagnosis of cognitive	S5054		

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S5054	Continued From page 17 impairment and required 30 minute safety checks around the clock. The following concerns were identified: a. Review of the safety check log showed on 12/20/23 the resident was checked at 5:30 PM and not checked again until 10:30 PM. On 12/22/23 the resident was checked at 8 PM and not checked again until 10 PM. On 12/23/23 the resident was checked at 5:30 AM and not checked again until 10 AM. On 12/24/23 the resident was checked at 5:30 AM and not checked again until 7 AM. On 12/25/23 the resident was checked at 5:30 AM and not checked again until 7 AM. 5. Interview with CNA #2 on 12/26/23 at 9:50 AM revealed 30 minute checks and safety checks were to be performed on every resident at the facility. At that time, the CNA demonstrated where documentation of the checks should be performed and revealed the checks were to ensure all residents whereabouts were known and they were accounted for. 6. Review of the emergency procedure drills for the last 12 months showed there were two elopements, one on 4/12/23 and the other on 10/9/23 with no evidence drills had been conducted before or since the elopements. Further review showed the elopement on 10/9/23 started at 3:30 AM and ended 30 minutes later. 7. Review of the facility's policy "Elopement Risk Prevention/Missing Resident" dated February 2023 showed, "The Community strives to promote resident safety and protect the rights and dignity of the residents. The Community maintains a process to assess all residents for risk for elopement..." the policy included procedures for evaluation, prevention,	S5054		

Healthcare Licensing and Surveys

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S5054	Continued From page 18 intervention, documentation, elopement drills and education. Elopement drills are to be conducted "on a regular basis, (at a minimum semi-annually)" and "utilize the results for staff education."	S5054		