STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165220	A. BUILDING _____ B. WING _____	**09/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AZRIA HEALTH PRAIRIE RIDGE	**608 PRAIRIE STREET MEDIAPOLIS, IA 52637**

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 **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** Based on clinical record review, observations and interviews the facility failed to provide adequate supervision to a high risk and cognitively impaired resident to prevent elopement for 1 of 3 sampled (Resident #1). Resident #1 exited the facility without staff knowledge on 12/28/19. This resulted in an Immediate Jeopardy. It was determined the wander device door alarm was unplugged and back up door alarm was silenced at the time of the elopement. The facility reported a census of 46. Findings included: The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #1 had a Brief Interview for Mental Status score of 6, indicating severe cognitive impairment. Resident #1 required extensive assistance for transfers, dressing, toileting use, personal hygiene and utilized a wheelchair for mobility. Resident #1 had [DIAGNOSES REDACTED]. A Wander Risk assessment dated [DATE], identified the resident with a score of 15 indicating a high a risk for wandering. The Care Plan with a completion date of 9/27/19 failed to address the resident's risk for elopement and failed to address the use of a wander device. Review of the Progress Notes from 4/27/19 to 12/3/19 revealed the following behaviors: a.On 4/27/19 at 6:57 a.m., Resident #1 crawled out of bed, reported he needed to meet his brother and wanted assistance so he, could get out of here. b. On 5/1/19 at 1:56 p.m., Resident #1 propelled his wheelchair through the front door before staff could get to him. He thought his daughter's vehicle was in the parking lot and wanted to go meet her. Resident #1 had a wander device in placed to his left wrist. c. On 6/9/19 at 11:15 p.m., Resident #1 became quite confused and cantankerous, wanted his shoes and his wife called to come pick him up. d. On 7/22/19 at 4:06 p.m., Resident #1 returned from an appointment with a new order for [MEDICATION NAME] 5 milligrams by mouth once a day for confusion. e. On 8/21/19 at 5:37p.m., Resident #1 attempted to exit the facility multiple times throughout the day to go home. The staff redirected several times with good outcome, but only lasted a little while. f. On 11/18/19 at 5:42 a.m., Resident #1 talking of the need to get his truck to pick up grain. g. On 12/3/19 at 6:41 a.m., Resident #1 up and awake all shift wandering without purpose in the wheelchair throughout the front area of the facility. The December 2019 Treatment Administration Record (TAR) documented Resident #1 had a wander device on the left wrist. The TAR directed staff to check every shift for wandering. The TAR had 3 omissions on the night shift and 19 omissions on the day shift. A Door Alarm Testing Log documented a door alarm check on 12/27/19 at 11:00 p.m. which included testing the door alarm, modules mounted on the door frame, red/green light functioning, range of door satisfactory, cables secure, wires frayed and a comment section. An Incident Report Form, dated 12/28/19, completed at 4:00 p.m., documented a large group of people exited the building from a Christmas party with cooler and gifts. Resident #1 followed the group of people out the door. The Incident Report documented the following vital signs after the incident: Temperature 97.7 degrees Fahrenheit, Pulse 108 beats per minute, Respirations 20 breaths per minute, Blood Pressure 138/62. The Incident Report identified the severity level of the incident at a Level 3, indicating an occurrence type which is considered to be at risk in nature; with or without injury (i.e. elopement, abuse, etc.). The untitled and undated (Facility Investigation),provided by the facility, identified Resident #1 had [DIAGNOSES REDACTED]. On 12/28/19 at 3:45 p.m., another resident told Staff A (Nurse Aide) that he saw another resident in the front circle drive going out toward the street. Staff A responded and observed Resident #1 propelling his wheelchair down the street headed east. Staff A reached Resident #1 390 feet from the front door of the facility. Resident #1 had a t-shirt, long sleeve shirt, sweatpants, socks and shoes on. Resident #1 reported he was on his way home. Staff A returned to the facility at 3:52 p.m. with Resident #1. The outside had a temperature of 50 degrees. The Director of Nursing (DON) performed a head to toe assessment and no injuries were noted. The staff notified the family and physician. The staff completed a count of all residents. The Document identified about 3:30 p.m. to 3:40 p.m. there had been 15 -20 people leaving the building after celebrating a Christmas party with their family member. The door alarm had likely been silenced as the visitors exited the facility. The document identified the door alarms were checked and all were functioning. The wander device the resident had been wearing also functioned properly, but the wander device monitor (control box) on the front door had gotten unplugged so the wander device alarm did not sound when the resident exited the facility. During an interview, conducted by the facility on 12/28/19, Staff A (Licensed Practical Nurse) reported another resident reported they saw Resident #1 outside the facility heading toward the street. Staff A ran out the front door of the facility. Resident #1 was wheeling his wheelchair down the street, east towards his house. The resident stated he was going home. Staff A reported she redirected Resident #1 easily. During an interview conducted by the facility on 12/28/19, the Director of Nurses (DON) reported 15 - 20 visitors exited the facility between 3:30 p.m. - 3:40 p.m. following a Christmas party. They carried out coolers and packages. It was not determined who silenced the exterior front door alarm. The DON reported likely the door had been silenced so the group could exit without the alarm sounding. Resident #1 exited with or directly behind the group prior to the (front) door shutting. It would have been very hard for the resident to have opened the door himself if it had not remained opened after or when the group left. A member of the group may have assisted the resident out the door if he said they were just going out to the porch. When gathering information and checking the alarms, it had been noted the wander device had become unplugged from the wall (by the front door). It had been immediately plugged back in and activated appropriately when tested . During an observation on 9/1/20 at 2:45 p.m., Staff B (Registered Nurse) walked to the front door, front wander device door, dining room door, East hall exit door, South hall exit door, beauty shop/patio door, back hallway wander device door and rear facility exit door and checked the function of the door alarm system and the wander device system. Staff B opened all doorways to set the door alarm off and utilized the wander device pendant to test all the wander device alarmed doors. All tested doors alarmed appropriately. Observation on 9/2/10 at 2:55 p.m. revealed the front wander device system plugged tight into the socket and unable to be removed from the socket. The wander device plug is up high on the right side of the door frame and could not be accessed without a stool or chair. The automatic door opener system had the door openers approximately 4 feet high from the floor easily accessible on the side of the door frames. The rear employee entrance wander device has the plug on the left side of the door frame on the back side of the door, which can still be manually unplugged. During an interview on 9/1/20 at 3:06 p.m. the State Climatologist reported on 12/28/19 a temperature of 52 degrees Fahrenheit, relative humidity100%, winds out of the southeast at 12 - 16 miles per hour gusting, visibility at 2 miles, no wind chill, and rain before and after the time period the resident had been outside of the facility. During an observation and interview on 9/1/20 at 3:00 p.m., Staff A (Licensed Practical Nurse) walked out the front door, which had revealed a large horizontal crack in the cement with a small slope down into the facility front driveway, then into the street heading east to the intersection of Prairie Street and North(NAME)Street where staff found Resident #1 propelling his wheelchair on the right hand side of the road across from a nearby parking lot, approximately 390 feet from the front door of the facility. The right side of Prairie Street had uneven areas. Staff A reported on 12/28/19 at 3:10 p.m. she arrived to work at 2:00 p.m. and had Resident #1's section.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165220	A. BUILDING _____ B. WING _____	**09/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AZRIA HEALTH PRAIRIE RIDGE	**608 PRAIRIE STREET MEDIAPOLIS, IA 52637**

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 **Residents Affected -** Few	(continued... from page 1) Staff A reported Resident #1 had no agitation or exiting seeking prior to the elopement, but had been missing his spouse. Resident #1's spouse visited earlier that day. Staff A reported another resident pointed out the window and informed Staff A that Resident #1 was outside. Staff A looked outside and observed Resident #1 propelling his out onto the street. Staff A immediately ran outside to retrieve Resident #1 who was easily redirected. Resident #1 stated he was going home where his spouse lives a few blocks away. Resident #1 always talked about going to see his spouse or get his truck. Resident #1 had a t-shirt, long sleeve shirt, sweatpants, socks and shoes on. Staff A reported she did not recall hearing any door alarms go off around the time of the elopement. Someone unplugged the wander device on the door but she didn't know who. A red light at the Nurses Station plane indicates the door is alarmed. The staff received education after the elopement to ensure the door alarms are not silenced unless the door is checked to ensure a resident has not gone out. She said there had been a note placed not to unplug the wander device system on the front door, but the wander device system had been replaced shortly after the elopement. She reported the nurses now check the door alarms every shift right after report along with checking the resident's wander device pendants are working. She said she always looks to see if the residents have their wander device on and would let the nurse know if they did not have it on. During an observation and interview with the Administrator, 9/2/20 at 3:25 p.m., she reported she didn't know what more the facility could have done. She reported the facility took all the following steps immediately: a. The DON assessed the resident once back in the facility. b. A headcount had been done to ensure all resident's account for in house. c. The wander device on the front door plugged in and all the door alarms tested to ensure working appropriately. d. Immediate education provided on 12/28/19 right after the elopement for all shifts. e. Reporting to the Iowa Department of Inspection and Appeals (DIA) Hotline number to report the incident. f. The Administrator initiated 15 minute checks on the wander device plug on the front door to ensure plugged in and placed a note stating if you ever had to unplug this for any reason, it must be immediately plugged back in. g. A Posting placed on the front door reminding visitors not to assist resident out of the facility without consulting the nurse first. The Administrator reported they had taken appropriate actions. The Administrator pushed the button to silence the front door. The front door could be opened for a full 10 seconds in silence mode without the door alarm being triggered. The Administrator reported she did not realize the door remained silenced for that long. The Administrator also noted both sets of double front doors have a hold open option that can be set on the control box above the each door. This allows both sets of doors to automatically stay open, but she didn't know if that had been done the day of the incident. On 9/1/20 the facility provide a Care Plan Item/Task Listing Report that shower the facility had five resident's care planned as elopement risk and currently wearing wander device bracelets due to the risk of wandering. During an interview on 9/2/20 at 11:53 a.m., Staff C (Registered Nurse) reported she had not been working at the facility very long when the incident occurred. She had been scheduled on the South hall that day. She stated the resident usually sits by the Nurses Station. He had exit seeking and it had happened before. He is usually always looking for his truck or to go home. She didn't recall any door alarms going off prior to the resident being out of the facility. She reported she did not provide any care to him that day and couldn't recall if there were many visitors in the facility that day. She stated she did not recall silencing the door alarm system or anyone asking her if they could silence the door alarm system that day. During an interview on 9/2/20 at 12:00 p.m., Staff D (Nurse Aide) reported she remembered the incident happened. She had not been caring for him that day, but believed he had been found outside the facility down by the assisted living at the end of the block. When he came back he looked nervous and glad to be back. He appeared to be shaken up from being outside. Staff D could not recall hearing a door alarm go off or anyone asking to have the door alarms silenced. We received education on the door alarm system right after it happened. The resident always thinks he is going somewhere. He can push the front first (wander device) door open but it triggers the Wander device alarm so we can get him. Staff D reported she did not know if the resident would be able to get the outside entrance door open. During an interview on 9/2/20 at 2:03 p.m., Staff A (Licensed Practical Nurse) clarified she had seen Resident #1 15 minutes prior to the elopement. The resident had been in the middle of the East hallway by the shower room sitting in the wheelchair. He had been asking about having a snack. Staff A stated she would get him a snack. Staff A clarified when she looked out the window of room [ROOM NUMBER], she saw Resident #1 in the wheelchair by the side of the road down across from the other parking lot, by the intersection. He had gotten a few more feet down the road before she went out to get him, but hadn't gotten far. Staff A reported Resident #1 did not comment on being cold, but had been asking where his spouse had been. During an interview on 9/2/20 at 3:00 p.m., the Administrator reported she had talked with a family member of the resident having a Christmas party and the family member stated her daughter had seen Resident #1 sitting in the wheelchair on the sidewalk when she left the facility, but could not recall what time that may have been. During an observation on 9/2/20 from 3:20 p.m. to 4:00 p.m. the following observations were made regarding traffic on Prairie Street in front of the nursing home: a. At 3:35 p.m., one car drove down the alley and turned onto Prairie Street heading west. b. There were two cars parked in residential driveways that could back out onto Prairie Street by the location the resident had been found on 12/28/19. c. One house with a two vehicles that could pull directly onto Prairie Street by the driveway of the facility where the resident exit heading East onto Prairie Street. d. At 3:40 p.m. one truck and one car traveled down Prairie Street heading East right by where the resident had been found 12/28/19. At the same time a car pulled into the parking lot right across from where the resident had been found. e. At 3:45 p.m. two vehicles traveled East down Prairie Street in the same path the resident had been on 12/28/19. f. At 3:50 p.m. two trucks traveled down Prairie Street heading East on Prairie Street in the same path the resident had been on 12/28/19. During an interview on 9/3/20 at 9:45 a.m., the Administrator reported she would check to see if they had a written procedure on how the nurses were trained to check the door alarm system and if they had a written protocol prior to the 12/28/19 elopement. She stated the door alarm check includes checking both the hard wired door system and the wander device alarm system. She reviewed the prior door alarm documentation sheet with the Surveyor. The undated Door Alarm Testing Log listed to document and check the date, time, tested , are the door modules securely mounted to the door frame, are the door modules securely mounted to the door frame, is the red/green light, range of the door modules satisfactory, are the cables secure, and are the wires frayed. The Administrator verified the nurses were to check and document on the sheet. She noted the changes to the new form stating that the old door alarm testing log had been the recommended log from the wander device manufacturer. They had changed the form after the elopement. She stated that if any employee notices anything abnormal with the door system, they are to report it to maintenance. She reported the wander device panel at the nurses station shows a green light for all the areas unless a resident is near the door, then it would be yellow. If a resident goes out the door it would light up red. Regarding the hard wired main door alarm system, the panel is located at the nurses' station. All the doors should light up in red to show the doors are alarmed. If the light goes to green, the door is disarmed. She stated any staff member can disarm the alarm system or silence the alarm system as long as they check the door alarm and check to be sure that a resident has not exited the facility. During an interview on 9/3/20 at 10:03 a.m., Staff B (Registered Nurse) confirmed the Door Alarm Testing Log had been the form used for documentation of the door alarm checks prior to 12/28/19. She stated that she checks the doors by opening the door and using the wander device pendant to check the wander device system. She reported she does not checked the cables/wires that would be something that maintenance would probably do. As long as the door alarm sounds when checked, the system is functioning. She reported if the alarm did not sound, she would report to maintenance immediately. During an interview on 9/3/20 at 10:25 a.m., The DON reported she worked the dayshift on the South hall that day (12/28/19). The nurses had been checking the doors daily prior to 12/28/19, but had not been documenting the checks well. The nightshift nurse is responsible for checking the doors daily and documenting. She reviewed the Door Alarm Testing Log documentation sheet and verified that the 10-6 shift did check the door alarm 12/27/19 at 2300. The DON reported the door alarm system had been checked the morning of 12/28/19, but the check had not been documented. The DON reported a typical staffing pattern the day of 12/28/20 when the resident eloped. Another Resident had a Christmas party that day and there were a lot of people in the facility. We try to have residents in a more visual area by the nurses' station or dining area to keep an eye on them. We also use the WanderGuard to alert us if a resident tries to leave the facility. The nurses check the doors and the WanderGuard pendants every shift now, to ensure the pendants are on and functioning. The door alarm check is not assigned to a nurse, either one of the nurses' can do the check. The DON reported Resident #1 had a history of [REDACTED]. We never were able to find out through our investigation who unplugged the WanderGuard system. Someone would have to have gotten up on a chair to be able to unplug the WanderGuard on the front door. Stated she never gave any staff approval to disengage the hard wire alarm door for the front door. No one would have been at the nurses' station at that time when the resident went out the front door. During an interview on 9/3/20 at 11:05 a.m., Staff F (Maintenance Director) reported he has a wander device that he tests the wander device system with weekly and monthly. He checks the wander device sensors at shoulder height, waist height and knee height. In December

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165220	A. BUILDING _____ B. WING _____	09/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AZRIA HEALTH PRAIRIE RIDGE	608 PRAIRIE STREET MEDIAPOLIS, IA 52637

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 **Residents Affected -** Few	(continued... from page 2) 2019 and January 2020 the front door had been tripping often, the wander device people said it could be the front TV that was setting it off. He had checked the wander device plug as part of his checks, but unplugging the wander device plug is the only way to reset the wander device on the door when it acts up. Staff F stated it is possible that the wander device on the front door had been acting up and had been unplugged due to that reason. He stated he had never found the wander device door (control box) unplugged during his checks. The new wander device control box installed 1/7/20 had the plug screwed into the socket and cannot be unplugged. He reported due to the wander device on the back employee entrance area, being older, is not screwed in and can still be unplugged. There is another set of hard wired alarm doors beyond that set of doors. Staff F stated he would provide the door check documentation as he does it for the TELS system monthly. During an interview on 9/3/20 at 1:01 p.m., Staff G (Licensed Practical Nurse) reported the nurses have always checked the door alarm system right after report but had not documented the checks until after Resident #1's elopement on 12/28/19. She could not recall if she had been the one checking the actual doors (on 12/28/19) or if she had been in the nurses' station resetting the alarms as the doors were checked that morning. The nurses check the door alarm system together. One (nurse) goes around and opens the doors and uses the pendant to set off the wander device system, the other resets the hard wired alarms in the nurses' station. She felt the door alarm system had been silenced when a family had been bringing in food and gifts for a family Christmas party, but she did not give anyone permission for the doors to be silenced. She reported the door alarms had been checked that morning but they were not documenting the checks at that time. The December 2019 untitled documentation sheet supplied by the Maintenance Director documented Fire doors and windows with a title inspection - latch and gap. The documentation failed to address any documentation of the door alarm system or wander device control box being plugged in. On 9/3/20 at 1:25 p.m., the Maintenance Director stated the sheet didn't document that, but he did check the alarm function and the wander device being plugged in as part of the check. On 9/8/20 at 9:30 p.m., the DON, reported a checklist is used during the orientation of nurses. She takes the nurses to each door and shows them how to open the doors and check the wander device system with the pendant and check the resident wander device bracelets. The undated Orientation Checklist provided by the facility lacked documentation to show nurses are trained in the door alarm system. During an interview on 9/8/20 at 12:39 p.m., Staff A (Licensed Practical Nurse) reported she believes that the DON or Staff E took her around and showed her how to check both the hard wired alarm door system and the wander device system using the pendant. The door has to physically be opened to set off the alarm and then the tested with the wander device pendant as well. She stated the wander device doors have to be reset from the actual door. The hard wired door system has to be reset at the panel in the nurses' station. She reported she was not aware that if any of the nurses were checking the door alarm system daily prior to Resident #1's elopement. After the elopement on 12/28/19, the facility provided training and the nurses started checking and documenting the door alarm system checks every shift. During an interview on 9/9/20 at 10:40 a.m., Staff H (Nurse Aide) reported she had received training on checking the door alarm system right after the elopement on 12/28/19. She reported if a door alarm goes off, they check at the nurses' station to see which door has been triggered. They physically go to the door to check to see if a resident has gotten out. If they don't see anyone by the door or outside the door, they report to the nurse and a head count is done of all the residents. She reported the wander device cannot be unplugged from the front door. During an interview on 9/9/20 at 10:45 a.m., Staff A and Staff B reported if a door alarm goes off, the nurses check the panel in the Nurses Station, both the hard wired panel and the wander device panel to see which door is alarming. The red light on the hard wired door panel will be flashing if a door has been opened. If a resident wearing a wander device is by the door, the wander device panel will show a yellow light. If a resident with a wander device opens a door or goes out a door the light will go from green to red. Staff A reported there were issues with the front door wander device going off all the time prior to the elopement and to reset the system the wander device plug had to be unplugged at the control box and plugged back in. That is why the wander device had been replaced on the front door. Both Staff A and B reported they received training on the door alarm checks after the elopement on 12/28/19. Staff A reported she received training regarding the door alarm checks for both types of doors and how to do the documentation. If a door alarm sounds, she would check in the Nurse's Station to see which door triggered and she or another staff member would physically go to the door to see if a resident is by the door or has exited the door. The alarm is not to be cleared until the door is physically checked. If no one is seen, the staff go out the door and check outside. If no resident or anyone is seen, they do a head count to see if all residents are accounted for. The door alarms are checked right after report on every shift. The residents wander device pendants are checked as they do the morning medication pass to ensure all pendants are working. She stated there is a mirror outside the nurses' station that allows them to be able to see the access to the back employee doors that have a wander device on them. During an interview on 9/8/20 at 1:16 p.m., a Family Member reported she attended the Christmas party. When she arrived the door alarms were going off as they were bringing food and other items into the home for the family Christmas party. She stated she did recall the alarms were going off throughout the day and there were a lot of visitors in the facility. She stated that another family member left just a few minutes before them and she observed staff bringing Resident #1 into the facility. The door alarms were active when she left the facility around 3:45 p.m. to 3:50 p.m. During an interview on 9/8/20 at 2:38 p.m., the DON reported she expects all nurses to check the main door alarm and wander device system every shift and document that the alarms are functioning. She expects a door alarm or wander device will not be silenced unless staff have physically gone to the door and visually checked to be sure a resident has not gone out the door. If no one is seen, then nurses are to do a headcount of all residents to ensure safety. During a phone interview on 9/15/20 at 10:32 a.m., the Administrator confirmed she observed Resident #1 on 9/15/20 wearing the wander device on his right wrist. However, the September 2020 TAR documented the wander device checked by staff on the left wrist. Observations from 9/1/20 to 9/14/20 revealed the wander device on Resident #1's right wrist. During an observation on 9/1/20 at 4:18 p.m., Resident #1 propelled his wheelchair out of the shower room. Resident #1 had a wander device bracelet on his right wrist. During an observation on 9/2/20 at 8:03 a.m., Resident #1 propelled the wheelchair back from the dining room after breakfast. Resident #1 had a wander device bracelet on his right wrist. During an interview on 9/2/20 at 11:15 a.m., Resident #1 stated it all happened so long ago, he really couldn't remember. The Wandering and Elopement Policy, effective 7/1/20 revealed a purpose to provide a system for identification of residents at risk for unsafe wandering and elopement, provide a program of supervision and interventions to minimize risk of resident elopement, improve resident safety through timely investigations of elopements and elopement attempts, and provide staff education in effective wandering/elopement management through in-services and elopement drills. The following Definitions were defined in the policy: a. Wandering - the act of moving (walking or locomotion in a wheelchair) from place to place with or without a specific course of known direction. Wandering may or may not be aimless. b. Unsafe Wandering - occurs when an at-risk resident, without supervision is exit seeking or attempting to leave the community/secured area but does not cross the threshold of a secured area. c. Elopement - when a resident (who is cognitively impaired) leaves the community/secured area without necessary authorization (i.e. an order for [REDACTED]. Elopement attempt - when a resident, without supervision is exit seeking or attempts to leave the community/secured area but does not cross the threshold of a secured area. The Policy included the following Environmental Control: a. Security devices on doors will be checked for function daily and documented. b. Alert devices, like wander device bracelets will be checked for replacement and function every shift and these checks will be documented in the medical record. The State Agency notified the facility of the Immediate Jeopardy on 9/9/20 at 12:05 p.m. During the survey initiated on 9/1/20 it was determined the facility abated the immediate jeopardy on 12/28/19. Past noncompliance was identified. On 12/28/19 the facility implemented testing of all door alarms for proper function, all wander device bracelets tested for proper function, educated staff to keep sight of disarmed doors, door alarm testing to be done every shift on all door alarms, fifteen minute checks for wander device plugged in, checks to continue until one keypad unit is replaced, new unit on order to arrive 1/7/20, note posted by wander device plug to never leave unplugged, and posted note on front door to visitors to never assist anyone out of the door without checking with a nurse first. The facility had the front door control module box for wander device system installed and sink screwed into outlet to prevent unplugging of the unit on 1/7/20.