STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145721	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Health Care East	100 Marian Parkway Sherman, IL 62684

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure R3 was adequately supervised and respond in a timely manner to alarms to prevent elopement for 1 of 1 (R3) resident reviewed for supervision. This failure resulted in R3 who is confused, has a history of exit seeking and wandering at the facility eloped into unknown and unsafe conditions that include exiting the facility, falling onto the concrete, log rolling to a handicap parking sign then sitting up and scooting on her buttocks through the facility parking lot alone until two bystanders observed R3 laying in the facility parking lot and stopped to assist her. This failure resulted in Immediate Jeopardy on [DATE] when R3 eloped from the facility exit door at 7:12 PM and was found by two bystanders at 7:18 PM and was assessed at the local hospital and returned to the facility.On [DATE] at 10:55 AM V1 Administrator, V2 Director of Nurses (DON) and V13, [NAME] President of Operations were notified of the Immediate Jeopardy.The surveyor confirmed by observation, interview and record review, the Immediate Jeopardy was removed on [DATE] but remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training.Findings include:R3's Undated Face Sheet documents she was initially admitted to the facility on [DATE] with diagnosis including unsteadiness on feet, history of falling, macular degeneration, depression, anxiety and diabetes. No diagnosis of dementia or Alzheimer's disease documented.R3's Baseline Care Plan, dated [DATE] documents she has some confusion, needs contact guard for transfer and bed mobility and staff dependent for assistance with personal care. Mobilizes with a wheelchair. Staff documented R3 was at risk for falls. R3's Care Plan Report, dated [DATE] documents resident was alert/oriented with much confusion and paranoid delusions and visual hallucinations. Resident sometimes wanders in/out of other residents' rooms due to confusion. Resident can be exit seeking when looking for family or dog. Goal: Resident will not leave the facility without staff or family supervision. No interventions documented to address resident's exit seeking or wandering behaviors.R3's admission Exit Seeking/Wandering Screener dated [DATE] documents score zero, staff documented no, resident not able to physically leave the facility on her own.R3's admission Minimum Data Set (MDS), dated [DATE] documents BIMS 9 and no behaviors exhibited including no wandering behaviors. R3's Health Status Note, dated [DATE] at 9:35 AM documents she was here for short term care.R3's Adv (Advanced) Skilled Evaluation dated [DATE] at 12:49 PM documents she is orientated to person and place and has mild cognitive impairment.R3's Social Service Note, dated [DATE] at 11:43 AM documents SSD (Social Services Director) CP (Care Plan) nurse met with resident and POA (Power of Attorney) today. Resident is alert/oriented with much confusion and forgetfulness. She has poor safety awareness and reasoning skills. She can be very anxious/restless and will sometimes attempt to get up by herself unsafely. 24-hour care recommended due to residents' confusion, cognition and poor safety awareness. Memory care facilities discussed in detail. SSD explained that if resident stays at facility and starts to become exit-seeking/elopement risk, alternative placement in a locked dementia facility would need to be considered. SSD explained that this facility was not equipped for memory care and exit seeking residents. This facility does NOT have locked doors, units, or (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	wanderguard systems in place for dementia exit-seeking residents. R3's Health Status Note, dated [DATE] at 7:07 AM documents patient noted to be restless and attempted to self-ambulate (walk), she stated that she was to meet her son to get the kids. Patient adamant that she needs her shoes on because she has a ride coming so she can leave. R3's Behavior Note, dated [DATE] at 5:40 PM, V10, LPN (Licensed Practical Nurse) documented resident crying, seeking elopement, attempting to stand though wheelchair bound, speaking and saying she sees things that are not here. Cursing. Constant redirecting, walking the halls with the resident. Nurse sat resident at nursing station to keep her close and safe. Kept constant communication with resident. R3's Exit Seeking/Wandering Screener dated [DATE] documents yes, R3 is physically able to leave the building on her own. No score on this assessment was documented. R3's Exit Seeking/Wandering Screener dated [DATE] documents yes, R3 is physically able to leave the building on her own, resident is disoriented to place, has impaired decision making, makes statements about going home, and displays persistent anger. Staff documented resident didn't have a history of wandering. Staff documented yes, resident has a current behavior of wandering.R3's Care Plan Report dated [DATE] additional interventions documented exit-seeking/attempting to exit facility without staff/family supervision: redirect resident away from facility exit doors. Wandering in/out of other residents' rooms: redirect resident out of the residents' room. Talk to resident in a calm and soothing manner. Offer resident a snack or something to drink. Take resident to the bathroom if needed. Redirect resident with group activities or other activities of interest. Listen to and address any worries or concerns. Provide reassurance and support as needed.R3's Social Service Note, dated [DATE] at 11:58 AM documents resident continues to be alert/oriented with much confusion and forgetfulness. She will sometimes wander in/out of other residents' rooms when confused, anxious, agitated, and looking for her family. She has potential to be exit seeking when anxious and looking for family. SS (Social Services) will add resident to elopement books for safety.R3's Social Service Note, dated [DATE] at 2:26 PM documents resident has been wandering up/down hallways and going in/out of other residents' rooms. Continuous redirection given. R3's Social Service Note, dated [DATE] at 2:45 PM documents SSD and Administrator contacted POA via phone early this afternoon. Resident has been wandering up/down hallways and wandering in/out of other residents' rooms. Due to her wandering, staff are having to provide 1:1 supervision for resident. SSD and Administrator told POA that due to resident's wandering and impulsive behaviors, facility will need family to search for alternative placement in a facility that can provide the dementia cares in a secured memory care unit. Administrator and SSD reminded POA that this facility does not have a secure memory care dementia unit. Administrator also informed POA that facility cannot continue to provide continuous 1:1 supervision with resident due to needing to meet the needs of other residents on their hallways in the facility. Resident is very restless this afternoon. She has been wandering up/down hallways, wandering in/out of other residents' rooms, exit seeking, and attempting to get up by herself unsafely.R3's Social Service Note, dated [DATE] at 4:30 PM documents SSD checked in on resident and stayed with resident until POA arrived this afternoon. She continued to be alert/oriented with much confusion. She was very anxious, restless, and agitated. She kept wheeling herself up/down hallways and going in/out of other residents' rooms and toward exit doors. She kept trying to get up by herself unsafely. She kept asking for her POA and family. She kept asking for a cigarette. Snacks, drinks, etc. offered. POA arrived to the facility around 3:30 pm. Resident continued to be very restless due to sundowning dementia. SSD talked to POA about discharge plans and alterative placements at great length. POA also voiced understanding to safety concerns regarding her exit-seeking and wandering behaviors. R3's Health Status Note, dated [DATE] at 10:21 AM documents received call from R3's PCP (Primary Care Provider), V11's office requesting an update on patient's behavior. Told office nurse that social services has had conversations with POA regarding patient needing placement in a memory unit. No new orders at this time.R3's Social Service Note, dated [DATE] at 9:50 AM documents SSD discussed with POA residents' wandering behaviors.R3's Social Service Note, dated [DATE] at 4:07 PM documents resident continues to have (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	much confusion d/t (due to) dementia. Resident wanders in and out of other resident's room. Much redirection given.R3's Health Status Note, dated [DATE] at 11:26 PM V9, Registered Nurse documented Resident was noted with multiple behaviors this shift such as exit seeking. On call MD, POA, on-call manager and all appropriate parties notified.R3's Social Service Note, dated [DATE] at 3:17 PM SSD and staff have redirected resident multiple times. Resident is very confused due to dementia. She has been wandering up/down hallways and in/out of other residents' rooms. Continuous redirection given all day by CNA, nurse and therapy staff.R3's Health Status Note, dated [DATE] at 4:00 PM V7 documented resident was trying to elope through dining room door and main exit on her hall.R3's Social Service Note, dated [DATE] at 9:27 AM documents SSD, PT/OT, DON, and Administrator met with POA today. Resident is alert/oriented with much confusion and forgetfulness. She is easily distracted and has poor safety awareness. She needs assistance with all decision making. She is impulsive and frequently attempts to get up by herself unsafely. She will wander to exit doors and in/out of other residents' rooms. Due to her wandering behaviors alternative placement or discharge will need to be sought. SSD discussed memory care again with POA. R3's Health Status Note, dated [DATE] at 9:15 PM V8, Registered Nurse (RN) documents resident was found outside of back door on her bottom. Assessment done. Skin tear on right hand. EMS (Emergency Medical Services) dressed the skin tear. VS (vital signs) stable. Confused to all spheres, she did know her name. POA and PCP notified of incident. R3's Health Status Note, dated [DATE] at 11:00 PM V8 documents resident transported to local hospital for evaluation. On [DATE] at 10:15 AM V1, Administrator and Illinois Department of Public Health (IDPH) Surveyor went to the door that R3 eloped from. V1 put a code in on the keypad and exited the double doors to the parking lot. V1 showed the IDPH surveyor where the resident was when the bystanders found her in the parking lot. Straight ahead was a very busy four lane highway with heavy traffic. V1 stated that four lane highway is the main highway through this town and it's busy all day and night. On [DATE] at 12:25 PM the surveyor opened the exit door that R3 eloped from which was next to the nurse's station and the door alarm sounded. Staff turned the door alarm off shortly after. On [DATE] at 10:35 AM the facility's wander/elopement book was reviewed and R3 was documented on the list. On [DATE] at 12:11 PM V7, LPN stated she was assigned to R3 on [DATE] from 2:00 PM to 6:00 PM. V7 recalled R3 was very confused and wandered a lot during that shift. V7 stated R3 was yelling out and was sundowning that shift and was wandering into other residents' rooms trying to find her dog. V7 stated R3 pushed on the exit door in the dining room and set the exit door alarm off near the nurse's station during that shift. V7 stated she continued to redirect R3 away from the exit doors and she didn't report to staff that R3 was attempting to get out exit doors because she didn't get out and she didn't get hurt and she didn't see what the importance of reporting those behaviors to management was. V7 stated she documented R3's exit seeking behavior in her nurse's notes and assumed management read over the nurse's notes so they'd know R3 was exit seeking. On [DATE] at 1:02 PM V10, LPN stated she was assigned to R3 on [DATE] from 2:00 PM to 6:30 PM. V10 stated she picked up the four-hour shift to help the facility out. V10 stated she got nurse report that R3 was very confused and was a wander and shortly after the day shift nurse left R3 started wandering down the hall by self-propelling in her wheelchair. V10 stated she recalled R3 telling her that she wanted to go home and that her husband was going to pick her up. V10 stated she observed R3 self-propelled to the exit door by the nurse's station and looked out. V10 stated she and the CNA redirected R3 away from the exit door often because she didn't want R3 to attempt to leave the facility. V10 stated her and the CNA kept a constant eye on R3 that shift because they were concerned for R3's safety and wanted to ensure she was going to leave the facility or attempt to leave the facility by herself. V10 stated she didn't report R3 was looking out the exit door or that she stated her husband was going to pick her up because she didn't feel that was important to report to management. On [DATE] at 10:27 AM V9, RN stated he is an agency nurse and worked night shift from 6:00 PM to 6:00 AM on [DATE] and was assigned to R3. V9 stated R3 had multiple behaviors that shift, and he wasn't familiar with her. V9 stated R3 was alert to name only and (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	she was really confused. V9 stated R3 wandered around the halls self-propelling in her wheelchair up and down the hall. V9 stated he didn't know if R3 was an elopement risk because he is an agency nurse but stated he noted R3 was staring out of the exit doors on her hall including the exit door located at the nurse's station. V9 stated he kept redirecting R3 from the exit door because he didn't want her to get out of the facility by herself. V9 stated he didn't feel R3 had safety awareness because she attempted to stand up on her own and she wasn't steady on her feet and was a fall risk. V9 stated he called the on-call nurse (name unknown) and let the on-call nurse know R3 was having a lot of behaviors and was looking out the exit doors and he was concerned R3 would try to leave the facility if he hadn't redirected her away from the exit doors that shift. V9 stated he documented R3 was exit seeking but wanted to clarify that R3 didn't set the exit door alarms off because he redirected her away from the doors multiple times that shift and wanted to ensure R3 stays safe in the facility.On [DATE] at 2:15 PM V6, Certified Nurse Assistant (CNA) stated she worked night shift starting at 6:00 PM on [DATE] and was assigned to R3 that shift. V6 stated she and R3 were close, and she was very familiar with R3. V6 stated R3 had multiple behaviors including wandering up and down the hall and into other residents' rooms. V6 stated she always knew to keep a close eye on R3 because she wandered so much, and she was very confused. V6 stated R3 was alert to name only and recalled R3 told her one time that her husband was deceased then another day R3 had a bag of her belongings packed and stated her husband was going to pick her up to go get the kids. V6 stated R3 packed her belongings at the facility four times, one time in a reuseable tote bag, another shift a grocery bag, another shift collecting her belongings on her bed and another shift R3 put all her belongings in her lap and was heading to the exit door by the nurse's station, but she redirected her prior to R3 getting to the exit door. V6 stated when she got to the facility on [DATE], she recalled R3 was sleeping sitting up in her wheelchair at the nurse's station on her hall. V6 stated she stayed up there and charted a while then another resident put their call light on to get a shower. V6 stated she was the only CNA on the hall and was assigned ten residents, including R3 so she thought she'd go and shower the other resident while R3 slept at the nurse's station. V6 stated she was done showering the resident within 15 minutes and when she opened the resident's door, she heard an alarm. V6 stated she ran to the nurse's station and didn't see R3 at the nurse's station then she ran outside the exit door located right next to the nurse's station and noted R3 was outside with two people she didn't know and a police officer. V6 stated she ran inside and reported to the charge nurse, V8, that R3 was outside sitting on the ground and she was bleeding. V6 stated V8 immediately followed her outside and assessed R3 at that time. V6 stated she didn't know R3 was outside while she was showering another resident and didn't know how R3 got outside and didn't know how long she'd been outside before the bystanders came to assist her. V6 was very upset that R3 got outside by herself because she was so confused and she could have gotten really hurt. On [DATE] at 11:00 AM V8, RN stated she worked with R3 often and was assigned to her on night shift on [DATE] starting at 6:00 PM. V8 stated R3 was very confused and didn't have safety awareness, R3 often wandered up and down the hall and in and out of other resident's rooms. V8 recalled when she got to the facility that evening R3 was at the nurse's station dozing in her wheelchair. V8 stated R3 was a resident you had to keep your eyes on at all times because she was very confused. V8 stated she was assigned two halls that shift, as always and she got report on R3's hall at 6:00 PM then went and got nurse report on the other hall and started administering medications to the other hall. At one-point (time unknown) V6 ran to her while she was on the other hall and reported R3 was outside, and she was hurt. V8 stated she followed V6 to the exit door near the nurse's station where R3 was initially sleeping at and observed R3 was sitting on the ground with 2 unknown people at her side and a police officer was there as well. V8 asked R3 what happened pointing to her hands and knee that were bleeding and stated R3 looked up at her and said I don't remember. V8 stated she didn't understand why the police were at the facility with R3. V8 stated she assessed R3 and took her vital signs at that time which were within normal limits. V8 stated R3 was very confused and didn't have safety (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	awareness. V8 stated she knew R3 was a wander but didn't think R3 would attempt to leave the facility on her own. V8 stated R3 should never have been left alone at the nurse's station, even if she was sleeping because she has a history of wandering. V8 stated she didn't know V6 was going to leave R3 at the nurse's station alone while she showered another resident and if she told her that she would have taken R3 with her to keep an eye on her while she administered medications on the other hall until V6 was done showering the other resident. V8 stated she didn't observe R3 set exit door alarms off and didn't see R3 attempting to open an exit door because she told night shift staff to keep R3 away from exit doors because she was a wander and she wanted to ensure R3 was safe.On [DATE] at 9:02 AM V4, SSD stated R3 was admitted to the facility for short term rehabilitation after falling at home and she had a diagnosis of dementia. V4 stated when R3 was admitted to the facility late February 2026 she immediately knew this was not an appropriate facility for the resident to reside at because of her behaviors, including wandering into other residents' rooms and up and down the hall. V4 stated she documented R3 was not an appropriate resident for this facility throughout R3's medical record because she was really concerned about her safety regarding wandering behaviors. V4 stated she didn't see, and no staff told her that R3 touched an exit door or set an exit door alarm off, but she would self-propel in her wheelchair to the exit doors and staff redirected her throughout the shift. V4 stated she documented R3 on the wander/elopement list mid-[DATE] because she was wandering into other resident rooms, not because she was attempting to elope the facility. V4 stated she documented that because she wanted to ensure staff knew she wandered, V4 stated she didn't think R3 had the physical capacity to get exit doors open, so she wasn't concerned R3 was going to elope or attempt to elope from the facility. On [DATE] at 10:02 AM V3, Assistant Director of Nurses (ADON) stated she was very familiar with R3 and stated she had many behaviors, including wandering about the facility. V3 stated R3 was very confused and was alert to name only and R3 had no safety awareness. V3 stated these wandering behaviors got worse at night, and she would often stay late and sit with R3 so staff could take care of other residents. V3 stated she was assigned to R3 on [DATE] day shift and recalled she was her usual self that day, anxious, restless and wandering throughout the halls. V3 stated she wasn't at the facility at the time R3 eloped.On [DATE] at 10:55 AM V2, Director of Nurses (DON) stated her understanding when R3 was admitted to the facility was she was being taken care of by family at home then she had a fall, and she was admitted to the facility for short term rehabilitation. V2 stated upon admission she didn't know R3 had behaviors including wandering. V2 stated shortly after R3 was admitted to the facility staff reported that R3 was very confused and wandered in and out of other resident rooms and staff had to redirect R3 often. V3 stated R3 needed alternative placement because she needed a locked memory care unit due to her wandering behaviors, and this facility isn't a locked facility and doesn't offer memory care. V2 stated she reviewed R3's medical records and she does not have a diagnosis of dementia or Alzheimer's disease, but she thinks R3 needs to be assessed due to her very confused cognitive state. V2 stated no staff reported to her that R3 packed up her belongings four times or that R3 told staff to help put her shoes on because her family was going to pick her up. V2 stated no staff reported to her that R3 set off exit door alarms or that R3 was attempting to open exit doors. V2 stated she expected staff to report that to her or other management immediately so they can put interventions in place to prevent R3 from eloping the facility. V2 stated if she knew R3 was pushing on exit doors and attempting to elope the facility she would have placed R3 on 15 or 30 minute checks and called R3's family to come sit with her. V2 stated she could have also assigned 1:1 staff to sit with R3 to ensure her safety if that was needed. V2 stated she wasn't aware of R3 ever being a 1:1 while at the facility. V2 stated after staff were aware of R3's wandering behaviors staff documented her name on the wander/elopement list, but it was more for wandering because V2 stated she wasn't aware R3 was an elopement risk. V2 stated R3 did not have safety awareness and if she would have go to the busy four lane highway in front of the facility she could have got hit by a car and could have died. On [DATE] at 10:45 V1, Administrator and V17, Maintenance Director showed the surveillance (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	camera of R3 eloping from the facility. V1 stated this occurred on [DATE] and the surveillance footage recording started at 7:00 PM which showed R3 was sitting up in her wheelchair at the nurse's station asleep. At 7:06 PM R3 woke up and took a drink. At 7:12 PM R3 self-propelled in her wheelchair from behind the nurse's station and saw the exit door which was right next to the nurse's station. R3 pushed on the door and was out the first door at 7:12 PM. R3 then self-propelled to the second exit door and got the exit door open but had difficulty getting her wheelchair through the second exit door. R3 attempted to stand and fell out of the second exit door, onto the concrete outside of the second door at 7:13 PM. R3's wheelchair was left between the two doors. R3 then did three log rolls to the parking lot where she reached out and held onto the handicap sign to sit up. At 7:16 PM R3 scooted on her buttocks and hands in a forward motion in the parking lot. At 7:18 PM two bystanders stopped by to check on R3 and the resident scooted out of view of the surveillance camera at that time. On [DATE] at 7:41 PM V17, V18, Bystander #1 stated she was the passenger in a vehicle on [DATE] around 7:10 PM and saw an elderly woman sitting in the parking lot of a nursing home from the highway and she told the driver (V19, Bystander #2) that he needs to pull over and they need to help that lady. V18 stated when she got to the resident, she was bleeding from both hands and from her knee and she only knew her name. V18 stated when they pulled up, she noted no staff were outside with the resident and the resident was really confused and screaming, HELP, HELP, HELP. V18 stated she directed V19 to go find nursing home staff and let them know she's outside by herself and she's injured. V18 stated she sat with the resident while V19 went to get help from nursing home staff. V18 stated the resident only knew her name and she was very scared and kept screaming for help even though she was sitting with her and reassured her they were getting her help. V18 stated a few minutes later V19 came back and stated he initially couldn't find any staff but then he found one (staff name unknown) and reported that there was an elderly woman outside sitting in the parking lot and was injured and needed assistance and the staff shrugged their shoulders and didn't follow him out of the facility. V18 stated when V19 came back to her and the resident sitting outside without staff they called 911 and reported the resident was outside sitting in the parking lot and she was bleeding and very confused. V18 stated the police arrived very fast to the facility and they took over and a few minutes later nursing home staff ran out and asked how the resident got outside in the first place and V18 told them she saw the resident sitting outside in the parking lot by herself and she knew something was wrong so that's why she stopped to assist. V18 stated they left after EMS took the resident to the local hospital. On [DATE] at 8:40 PM V19 stated he was driving down a four lane very busy highway that was located next to a nursing home on [DATE] at approximately 7:13 PM and V18 told him to pull into the parking lot because there was a nursing home resident sitting in the parking lot by herself. When they arrived to the parking lot V18 opened the door and he heard the resident yelling/screaming, HELP! HELP! HELP! V18 told him she'd go sit with the resident and he should go tell staff she's outside alone and she's bleeding. V19 stated she drove to the main entrance of the facility and looked for staff after finding a staff member (name unknown) he reported an elderly resident was outside and she was bleeding and needed staff assistance. V19 stated the staff member didn't follow him to go assist the resident so he drove back to where the resident and V18 were. V19 told V18 staff didn't follow him, and they decided to call 911 and the police arrived to the facility a minute later to assist the resident. V19 stated it was for several more minutes that facility staff came outside to assist the resident. V19 stated he knows staff weren't aware the resident was outside, and he was really concerned because the resident was very confused, and the busy 4 lane highway was located right in front of the facility and the resident could have really got hurt if she attempted to cross the highway. On [DATE] at 9:51 AM V1, Administrator stated a resident (R3) recently eloped from the facility and bystanders saw her in the parking lot and stopped to assist. V1 stated R3 was on the wanderer/elopement list because she wandered into other residents' rooms but that R3 didn't exit seek while she resided at the facility. V1 stated R3 was admitted to the facility at the end of February 2026 for short term rehabilitation and she wasn't aware that R3 had wandering behaviors prior to (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	admission. V1 stated no staff reported that R3 packed up her belongings, that R3 stated her husband was going to pick her up or that R3 attempted to get out of an exit door or that R3 had set an exit door alarm off before. V1 stated if R3 was doing those things she expected staff to report that to her or the DON so they could put interventions in place to keep R3 safe. V1 stated it was clear to her that shortly after R3 was admitted to the facility the facility was not proper placement for her because she had behaviors including wandering and they were not a memory unit nor a locked unit which is what R3 needed due to confusion and wandering behaviors. V1 stated when staff documented R3 on the wander/elopement sheet it was only due to R3's wandering behavior, not that she was an elopement risk. V1 stated she reviewed the surveillance camera and noted when R3 eloped at approximately 7:13 PM on [DATE] she was at the nurse's station sleeping prior to and then and when R3 woke up she went directly to the exit door next to the nurse's station and got out of the facility. V1 stated as she watched the surveillance camera two people pulled up in a vehicle at some point and assisted R3. They called the police and R3 was transported to the local emergency room. V1 stated she arrived at the facility shortly after R3 was taken to the hospital and staff reported to her that R3's hands and knee were bleeding. V1 stated when R3 was getting out the exit doors the CNA was showering another resident, and the assigned nurse was administering medication on another hall. V1 stated she interviewed both staff and they stated they didn't know R3 was outside, how she got outside or how long she was outside by herself. V1 stated stuff like this doesn't happen at this facility and she was actively working with R3's POA to get her the proper care she needed at a memory care locked unit because this facility wasn't appropriate for her.On [DATE] at 3:43 PM V12, Deputy Chief of Police stated a police officer was called to the facility by a passerby and stated an elderly resident was sitting in the facility parking lot by herself yelling for help. V12 stated the responding police officer was a block away when he received the call on [DATE] at 7:19 PM and the officer was on scene within 30 seconds. V12 stated the police officer noted the resident was very confused and was bleeding from both wrists/hands area. V12 stated the police officer interviewed the resident but she was really confused and only knew her first name. V12 stated the officer asked the resident how she got outside, and the resident didn't know how she got outside. V12 stated no nursing home staff were outside with the resident when the officer arrived to the scene, they started coming out of the facility a few minutes later. The officer stated nursing home staff didn't know how the resident got out of the facility but that she shouldn't be outside by herself due to her confusion. V12 stated there wasn't a police report documented for this 911 call because no laws were broken.On [DATE] at 10:32 AM V11, R3's PCP stated he has been R3's PCP for over 20 years. V11 stated he assessed R3 in his office last on [DATE] and R3 was alert and seemed oriented with bouts of confusion. V11 stated R3 had not been diagnosed with dementia but it was questionable due to over the last year he could tell R3 had declined cognitively. V11 stated R3 had no insight and no safety awareness and due to being confused she wouldn't be able to cross a busy four lane highway and be cognizant to look both ways for cars. V11 stated when R3 eloped from the facility she could have got severely hurt including getting hit but a car on the busy four lane highway that is directly out front of the facility, and she could have died. V11 stated when R3 attempted to elope from the facility and set exit door alarms of prior to eloping staff should have reported that to management and they should have implemented interventions to prevent R3 from eloping. V11 stated no facility staff called his office to report R3 was exhibiting exit seeking behaviors and if she was exhibiting exit seeking behaviors, he expected staff to document the behaviors and to also assess and document interventions to prevent R3 from eloping from the facility and keeping R3 safe. R3's ED (Emergency Department) Physician Notes, dated [DATE] documents the patient presents with [AGE] year-old with PMH (previous medical history) of dementia (close to baseline per EMS) presents after fall. The patient reportedly eloped from her nursing home and was found outside the building. Patient is complaining of right knee and right hip pain, she denies LOC (loss of consciousness), she is awake, alert and orientated to self and place. Medical history: neurological: dementia. Physical e[TRUNCATED]