STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365392	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky River Gardens Rehab and Nursing Ctr	4102 Rocky River Dr Cleveland, OH 44135

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(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** 44457 Based on observation, medical record review, review of the facility investigation, hospital record review, review of the facility root cause analysis, review of facility policy and interviews, the facility failed to provide adequate supervision and monitor WanderGuard (wearable device to help keep residents at risk of wandering safe) functioning for Resident #69, a resident with a history of exit seeking behavior to prevent elopement. This resulted in Immediate Jeopardy and the potential for serious harm, injury and/or death on [DATE] at approximately 7:44 P.M. when Resident #69 eloped from the facility without staff knowledge, through a smoking patio exit door and traveled from Ohio (OH) to Wisconsin (WI), under unknown circumstances. Resident #69 was not seen by facility staff for nearly three hours before he was discovered missing at approximately 10:30 P.M. Resident #69 was missing from the facility for over two days when he was found on [DATE] by a university police department on a college campus in WI, approximately 425 miles away from the facility. Resident #69 was subsequently transported to a local hospital in WI for evaluation and treatment and then transferred back to the facility on [DATE]. During the time Resident #69 was missing, the resident missed hemodialysis (treatment that filters waste and excess fluid from the blood when the kidneys are unable to) treatment and several prescription medications including those to treat high blood pressure, angina (chest pain) and mental illness. This affected one resident (#69) of six residents reviewed for elopement. The facility census was 101. On [DATE] at 2:52 P.M. the Administrator, Regional Director of Operations (RDO) #800 and Regional Director of Clinical Services (RDCS) #801 were notified that Immediate Jeopardy began on [DATE] at approximately 7:44 P.M. when the facility failed to provide adequate supervision and ensure a functional WanderGuard for Resident #69. Resident #69 was able to exit the facility, without staff knowledge, through the smoking patio door and traveled out of state, approximately 425 miles away, under unknown circumstances. Resident #69 was placed at increased risk due to the unknown circumstances of his travel to WI and medical treatments, (including dialysis and medications) not being provided. Resident #69 was not located until [DATE], at which time he was transported to a local hospital in WI for evaluation, treatment and supervision until he was transported back to the facility on [DATE]. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: On [DATE] at 10:30 P.M., Registered Nurse (RN) #811 was unable to locate Resident #69 for medication administration and instructed State tested Nursing Assistant (STNA) #823 and STNA #824 to search the unit. (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	On [DATE] at 10:45 P.M. RN #811 called a code and Licensed Practical Nurse (LPN) #825 and LPN #826 searched all facility floors and outside areas. On [DATE] at 11:01 P.M., RN #827 notified the Director of Nursing (DON) that Resident #69 was missing. The DON instructed RN #811 to complete a resident head count of the entire facility and obtain witness statements from all staff present at that time. On [DATE] at 12:00 A.M., Police Officer (PO) #834 arrived from the local police department and took a report from RN #811. RN #811 provided the officer with Resident #69's demographic information, the last time he was seen and a brief description of what he was wearing (blue jeans, a white and blue striped shirt and a navy-blue lightweight jacket) prior to the elopement. On [DATE] at 6:00 A.M., a root cause analysis was conducted by RDO #800, RDCS #801, the Administrator and the DON. The root cause of Resident #69's elopement was determined to be a system failure to ensure the resident ' s WanderGuard was in place and/or functional and adequate supervision. On [DATE] at 6:15 A.M., RDO #800 re-educated the DON and the Administrator on the facility's elopement policy and best practice, WanderGuard protocol, elopement risk assessments and interventions, door alarm response and adequate supervision of residents. On [DATE] at 8:00 A. M., the DON initiated in-person education with all facility staff on the elopement policy and best practice, WanderGuard protocol, elopement risk assessments and interventions, door alarm response and adequate supervision of residents. Dietary Manager (DM) #828, Housekeeping Director (HD)#806, Activities Director (AD) #808 and Assistant Director of Nursing (ADON) #838 assisted with the education, after receiving the education from the DON and/or Administrator. By 4:30 P.M., 113 of 113 staff received the education. Education will be provided for all new employees during orientation. On [DATE] from 10:30 A.M. to 1:30 P.M., ADON #838, Unit Manager (UM) #829 and Wound Nurse (WN) #830 re-assessed all residents for elopement and verified care plans were up to date. On [DATE] at 10:15 A.M., Director of Maintenance (DOM) #804 checked all doors equipped with WanderGuard sensors to ensure functionality. On [DATE] at 11:00 A.M., an Ad-Hoc Quality Assurance Performance Improvement (QAPI) meeting was held to review the root cause analysis, facility interventions, facility policies on wandering and elopement and facility response. In attendance were Medical Director (MD) #831, Primary Physician (PP) #802, the Administrator, the DON, AD #808, HD #806, Social Services Designee (SSD) #810, DM #828, Human Resources Director (HRD) #832, UM #829 and DOM #804. The Administrator re-educated attendees on the elopement policy, WanderGuard protocol, door alarm response and supervision of residents. On [DATE] from 11:30 A.M. to 1:30 P.M., RDCS #801 reviewed residents with WanderGuard orders (Residents #20, #30, #31, #35, #39, #40, #44, #49 and #51) to ensure placement and functionality of the WanderGuards and the residents' care plans were accurate. All reviewed residents had functioning WanderGuards in place and care plans were updated. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] from 1:00 P.M. to 4:00 P.M., Minimum Data Set Nurse (MDSN) #833 conducted a second review of all resident care plans and updated, as needed, to ensure all care plans accurately reflected elopement risk and WanderGuard use/interventions. Beginning on [DATE], DOM #804, or designee, would conduct checks of doors equipped with WanderGuard sensors five times per week for two weeks then weekly until [DATE]. Beginning on [DATE], the DON, or designee, would audit nine WanderGuard placement and function three times weekly for four weeks then one time weekly for four weeks. On [DATE] at 8:00 A.M., LPN #812 was notified by university police in Milwaukee, WI that Resident #69 was found on their campus. LPN #812 immediately notified ADON #838, who then immediately notified the DON and Administrator. On [DATE] at 9:00 A.M., university police transported Resident #69 to an area hospital for further evaluation due to missed medications and hemodialysis treatments. On [DATE] at 9:20 A.M., AD #839 and STNA #840 picked-up Resident #69 from the hospital in Milwaukee, WI and transported the resident back to the facility. On [DATE] at 7:09 P.M., Resident #69 returned to the facility. LPN #814 assessed Resident #69 and the resident was placed on one-on-one supervision for safety. The resident's WanderGuard was replaced and tested to ensure it properly functioned. On [DATE] at 8:00 P.M., RDCS #801 reviewed Resident #69's care plan for accuracy. On [DATE] at 2:28 A.M., LPN #837 reassessed Resident #69 for elopement risk. Resident #69 was assessed to be at high risk for elopement. On [DATE] at 6:00 P.M., DOM #804 conducted an elopement drill with no concerns identified with staff response. On [DATE], MDSN #833 updated Resident #69's care plan to include updated elopement risk and interventions. Resident #69's physician orders were updated to check WanderGuard placement and function each shift. On [DATE] at 4:00 P.M., DOM #804 placed an order for an additional WanderGuard testing device and WanderGuard bracelets to provide additional supplies. Beginning on [DATE], DOM #804, or designee, would conduct elopement drills/resident supervision on each shift weekly for four weeks and then monthly indefinitely. Beginning on [DATE], the DON or designee, would audit elopement assessments and interventions for accuracy and completeness weekly for four weeks. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews on [DATE] from 8:51 A.M. to 3:56 P.M. and on [DATE] from 11:35 A.M. to 2:43 P.M. with LPN #813, LPN #814, STNA #815, STNA #816, STNA #817, STNA #818, STNA #819 and STNA #820 verified the facility provided education on the elopement policy and procedure, WanderGuard protocol, elopement risk assessments and interventions, door alarm response and adequate supervision of residents. Review of the open medical records for five additional residents (#20. #35, #39, #40 and #49) revealed elopement assessments were completed, and care plans were reviewed and updated as needed. Although the Immediate Jeopardy was removed on [DATE], the deficiency remains at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: Review of the medical record for Resident #69 revealed an admitted [DATE] with diagnoses including schizophrenia, bipolar disorder, anxiety disorder, end stage renal disease with dependence on renal dialysis, left below knee amputation, cirrhosis of the liver, type two diabetes mellitus and essential hypertension. Resident #69 had a legal guardian and resided on the facility third-floor, long-term care unit. Review of the Admit/Readmit Progress Note, dated [DATE], revealed Resident #69 admitted to the facility with episodes of delusions and hallucinations. Resident #69 had a WanderGuard applied to his wheelchair as the resident was known to exit seek and become combative. Resident #69 admitted to the facility under supervision of a legal guardian. Review of a physician's order, dated [DATE], revealed an order for WanderGuard check every shift for location of the device. There was no evidence of an order to check the WanderGuard functionality. Review of the Statement of Expert Evaluation for the local county probate court, dated [DATE], revealed Resident #69 had mental impairment related to mental illness of schizophrenia, major depressive disorder, anxiety disorder and bipolar disorder. Resident #69 lacked insight and judgement into mental health diagnoses and lacked proper decision-making skills. The physician noted Resident #69 was not mentally or physically capable of caring for himself and guardianship should be continued. Review of the Elopement Review assessment, dated [DATE], revealed Resident #69 was assessed to be low risk for elopement. The assessment indicated Resident #69 had no elopement attempts in the last three months, was cognitively intact and ambulatory with the use of a wheelchair. Review of Medicare Minimum Data Set (MDS) Annual assessment dated [DATE] revealed Resident #69 had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. There were no noted wandering behaviors on the MDS assessment. Resident #69 was independent for dressing, bed mobility, wheelchair use, and transfers. Resident #69 used a wander or elopement alarm daily. The assessment revealed Resident #69 required dialysis. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the late entry social services progress note dated [DATE] at 11:32 A.M. revealed MD #831 was notified Resident #69 was not located in the facility. Review of the social services progress note dated [DATE] at 1:15 P.M. revealed Resident #69's guardian returned the phone call and was provided with an update on Resident #69. Review of the revised care plan, dated [DATE], revealed Resident #69 had history of cutting off the WanderGuard on [DATE]. Further review of the medical record revealed no information related to events or occurrences of Resident #69 attempting to remove the WanderGuard. Review of the general progress note dated [DATE] at 8:02 A.M. revealed the nurse received a call from a police department in Milwaukee, Wisconsin. Resident #69 was at the police station. The nurse gave police officer information on Resident #69's medical history. Resident #69 was sent to a local hospital in Milwaukee. The nurse notified Resident #69's guardian, physician, and ADON. Review of hospital records revealed Resident #69 arrived at the emergency room (ER) on [DATE] at 8:01 A. M. via ambulance. The resident reported no symptoms and last had dialysis three days prior. Resident #69 had labs drawn, a chest x-ray and an electrocardiogram (EKG - measures electrical activity of the heart). The hospital nephrologist (kidney specialist) recommended 30 milligrams (mg) of Kayexalate (treats high levels of potassium in the blood) and no dialysis treatment. Social work was consulted related to legal guardianship in Ohio. The guardian reported to hospital staff Resident #69 was in a locked facility, managed to elope and used public transportation to get to WI. The social worker reached RDO #800 at the facility to arrange Resident #69 ' s return. Resident #69 was scheduled to be picked up in a facility van by two facility staff on [DATE] at 9:00 A.M. Review of Interdisciplinary Team (IDT) note dated [DATE] at 8:26 A.M. revealed the IDT reviewed the root cause of Resident #69 leaving the facility. Interventions upon Resident #69's return included one- on-one supervision and exit doors would be monitored for proper function of WanderGuard equipment. Review of the admit/readmit progress note dated [DATE] at 7:09 P.M. revealed Resident #69 readmitted to the facility in a wheelchair. Resident #69 was alert and oriented to person, place, and time. Resident #69 had no complaints of pain or discomfort. Resident #69 was placed on one-on-one supervision until further notice. Resident #69's guardian, ADON, unit manager, and nurse practitioner were notified of his return. Review of the late entry nursing progress note dated [DATE] at 7:47 P.M. revealed staff obtained Resident #69's weight, provided a shower, obtained vital signs and completed a skin assessment. Review of the revised care plan dated [DATE] revealed Resident #69 was at high risk for elopement related to diagnosis of schizophrenia, history of attempts to leave the facility unattended and impaired safety. Interventions included to distract resident from wandering with pleasant diversions, structured activities, food, conversation, television, or books; identify a pattern of wandering; divert wandering as needed; intervene as appropriate; monitor for fatigue or weight loss, and wander alert to resident's wheelchair. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview on [DATE] at 11:20 A.M. with Program Manager (PM) #822 with the volunteer guardian program revealed on [DATE], at approximately 2:00 A.M., they received a call indicating Resident #69 was missing from the facility. PM #822 stated the facility noticed Resident #69 was missing during the nighttime medication pass on [DATE]. PM #822 reported they were informed Resident #69 left out of the smoking patio door and kept going. PM #822 indicated Resident #69 was in a wheelchair so she was unsure how Resident #69 could have gotten so far without anyone noticing. PM #822 stated on [DATE] they were notified Resident #69 was found in Milwaukee, WI, sitting on a bench on the university campus, by the university police. Resident #69 told the police he was waiting to meet with admissions about going to graduate school. PM #822 stated this was a common fixation for Resident #69. PM #822 explained Resident #69 was originally from New Jersey and traveled to Ohio under similar circumstances as his elopement to WI. While it was unknown how Resident #69 traveled to WI, it was believed he had been withdrawing money from his resident fund account and storing the funds prior to his elopement. PM #822 verified the facility Administrator reached out to her on [DATE] to discuss alternative placement for Resident #69. A telephone interview on [DATE] at 12:48 P.M. with Primary Physician (PP) #802 revealed he was notified immediately after Resident #69 was determined to be missing. PP #802 noted Resident #69 had schizophrenia and was always talking about going to a university. PP #802 was unaware if Resident #69 wore a WanderGuard but indicated he would suggest one. PP #802 noted Resident #69 would have missed dialysis and medications while in the community. Interview on [DATE] at 2:34 P.M. with LPN #812 revealed she worked from 7:00 A.M. until 7:00 P.M. on [DATE] and was assigned to Resident #69's unit. LPN #812 stated Resident #69 went to dialysis at approximately 8:00 A.M. that morning and returned at approximately 2:00 P.M. LPN #812 stated Resident #69 was agitated upon return from dialysis and had called 911, for unknown reasons, while he was at the dialysis clinic. LPN #812 stated Resident #69 was resting in bed when she completed rounds at the end of her shift. LPN #812 revealed she observed Resident #69's WanderGuard was in place. LPN #812 stated Resident #69's physician orders included checking placement of the WanderGuard; however, there was no order to ensure it was properly functioning. On [DATE], LPN #812 stated she received the phone call that Resident #69 was found in Milwaukee, WI. LPN #812 stated the police had picked the resident up when he was lingering around the police station and seemed off. LPN #812 stated she provided the police with the resident's medical and mental illness history and then she notified the unit manager of the phone call. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview on [DATE] at 2:53 P.M. with RN #811 revealed she was Resident #69's assigned nurse on [DATE] from 7:00 P.M. to 7:00 A.M. RN #811 stated she was told in report that Resident #69 had an incident at dialysis, received a Risperdal injection upon return to the facility and had been lying down for a few hours. At approximately 7:30 P.M., RN #811 stated she was standing at the medication cart when she saw Resident #69 in his wheelchair. RN #811 stated she asked the resident how he was doing and he indicated he was fine and proceeded down the hall to the elevator. RN #811 stated Resident #69 frequently utilized the elevator to go downstairs to the vending machines, so she was not concerned with his actions. At approximately 10:30 P.M., RN #811 stated she went to Resident #69's room to pass medications and he was not there. RN #811 indicated she asked other staff if they had seen him, without success. RN #811 was unable to locate Resident #69 and staff began searching the building, then searched outside the facility. At 11;01 P.M., when staff were unable to locate Resident #69, RN #811 called the DON. The DON instructed RN #811 to ensure a thorough search was completed and to call the police. The DON was going to call the guardian. RN #811 stated she gave report to the police, collected witness statements from staff and asked other residents if they had seen Resident #69. RN #811 confirmed Resident #69 wore a WanderGuard; however, she had not yet done her assessment to confirm placement. RN #811 stated she was unsure how the WanderGuard system worked as it did not alarm at the third-floor elevator. RN #811 indicated she did not check the functioning of Resident #69's WanderGuard, just the placement, and she did not know who was responsible for checking the functioning of his WanderGuard. RN #811 stated Resident #69's WanderGuard order was different than the other residents' because his asked about behaviors and not about functionality. Interview on [DATE] at 7:37 A.M. with the Administrator revealed he was notified Resident #69 was missing from the facility by the DON on [DATE]. He was unable to recall the exact time of notification. The Administrator indicated he met the DON at the facility and drove around the community looking for Resident #69 until about 7:00 A.M. on [DATE]. The Administrator indicated that he, and other facility management, continued to search the community for Resident #69 on [DATE] and [DATE]. The Administrator stated there was camera footage on [DATE] at 7:44 P.M. of Resident #69 getting off the elevator and going in the direction of the smoking patio. The Administrator indicated the camera footage overwrites after a few days and the footage from the evening Resident #69 eloped had not been retained; however, it was unclear how Resident #69 exited the smoking patio door as there was no camera footage in that area. The Administrator confirmed the smoking patio door was equipped with a WanderGuard sensor and should have alarmed. Observation on [DATE] at 7:46 A.M. of the door leading to the outside smoking patio, with the Administrator, revealed a locked door with a keypad next to the door. The door was equipped with the WanderGuard system. The patio was not fully enclosed and led out to the back parking lot driveway. The smoking patio door was located in a room with several tables. The room was located on an administrative hallway, which included offices, laundry and the kitchen. Observation on [DATE] at 7:53 A.M. with DOM #804 and Maintenance Assistant (MA) #805 revealed the smoking patio door was locked. DOM #804 held a WanderGuard, and the keypad indicated the system was in working order. DOM #804 stated the smoking patio door was locked from 8:00 P.M. to 8:00 A.M. and demonstrated that pushing on the smoking patio door for 15 seconds, while locked, would set off an audible alarm prior to the door releasing and opening. From 8:00 A.M. to 8:00 P.M., DOM #804 stated the door was unlocked but a functional WanderGuard would set off an audible alarm. DOM #804 further explained a functional WanderGuard would trigger the door to lock and then alarm if the door was pushed on. Continued observation confirmed the audible alarm was loud enough for staff working in resident care areas on the first floor to hear the alarm in order to respond. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 8:18 A.M. with RDO #800 revealed she was notified Resident #69 was missing by the Administrator on [DATE]. RDO #800 indicated she arrived at the facility on the morning of [DATE] to assist with search efforts. RDO #800 reported interviews with staff revealed no evidence of Resident #69's WanderGuard system alarming. RDO #800 stated she assisted with trying to obtain information on where Resident #69 might have gone. RDO #800 reported she called Resident #69's guardian to find out if he had any local friends or family that could be contacted. RDO #800 found that Resident #69 had taken out 130 dollars from his funds account over the previous two weeks. RDO #800 stated Resident #69's room was searched, with no indication of where he may have gone, and it did not appear the resident had taken any of his personal belongings. RDO #800 stated medical documents were found from a previous facility indicating Resident #69 had taken a bus from New Jersey to Ohio and was found disoriented at a bus stop needing dialysis. RDO #800 noted Resident #69 had a history of paranoia and was fixated on not being in a facility and going back to college. When Resident #69 was found the morning of [DATE], she coordinated transportation for the resident to be returned to OH from WI. RDO #800 reported the resident's WanderGuard was still attached to his wheelchair upon his return. RDO #800 stated the facility determined Resident #69 was able to leave the facility undetected as his WanderGuard was not in working order and it was replaced upon his return. Additionally, RDO #800 stated Resident #69 was placed on one-on-one supervision. RDO #800 indicated there was no written policy for WanderGuard use but the protocol was to check placement and functioning every shift. Interview on [DATE] at 9:05 A.M. with Resident #69 revealed Resident #69 refused to answer questions about why he left the facility and how he traveled to Milwaukee, WI. Resident #69 indicated he felt safe while out of the facility and had his coat on. Resident #69 stated he did not like it at the facility and asked if surveyor was going to take him back to WI. Resident #69 ended the interview. Interview on [DATE] at 10:46 A.M. with the Administrator, RDO #800, and RDCS #801 revealed they believed the cause of Resident #69's elopement was failure of his WanderGuard functionality. Interview on [DATE] at 11:35 A.M. with STNA #816 revealed on [DATE] he supervised the nighttime smoke break, which occurred at approximately 8:00 P.M. that evening. STNA #816 reported there was no evidence of the smoking patio door alarming or having been tampered with. STNA #816 denied seeing Resident #69 during the smoke break. Interview on [DATE] at 2:43 P.M. with STNA #815 revealed on [DATE] she was assigned to Resident #69's unit from 3:00 P.M. to 11:00 P.M. STNA #815 stated, at the start of her shift, Resident #69 was agitated and combative with staff. STNA #815 stated Resident #69 received a shot and slept in his room until 5:30 P.M., when the resident exit his room and stated he was going to the dining room. STNA #815 indicated she remained busy with patient care and was notified by RN #811 that Resident #69 was missing. STNA #815 indicated she assumed Resident #69 was in the dining room and had not checked on him as he did not need care from her, adding the resident was independent with activities of daily living (ADLs). Review of the Resident Trust Funds Withdrawal Authorizations revealed Resident #69 withdrew 50 dollars on [DATE], 50 dollars on [DATE], and 30 dollars on [DATE]. Review of the Root Cause Analysis dated [DATE] revealed staff failed to verify WanderGuard placement and function by root cause of inattention and knowledge deficit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365392	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky River Gardens Rehab and Nursing Ctr	4102 Rocky River Dr Cleveland, OH 44135

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	Review of the facility policy titled Wandering, Unsafe Resident, revised [DATE], revealed residents would be evaluated for risk of unsafe wandering or elopement, at risk residents may wear a Secure Care or other such bracelet for additional security and prevention, and the care plan would identify a detailed monitoring plan to ensure safety. Review of facility policy, Elopements, dated [DATE], revealed if an employee observes a resident leaving the premises they should attempt to prevent departure in courteous manner, get help from other staff, and instruct other staff to inform Charge Nurse or DON. This deficiency represents non-compliance investigated under Complaint Number OH00158807.