| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525371 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/30/2026 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bayshore Nursing & Rehab | 1300 West Silver Spring Dr<br>Glendale, WI 53209 |

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) |
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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and policy review, the facility failed to ensure two (Resident (R) 1 and R9) of four residents reviewed for physical abuse out of the sample of 11 residents were free from physical abuse. Specifically, in a resident-to-resident altercation, R2 hit R1 and R8 hit R9. These failure had the potential to cause harm for residents throughout the facility.<br><br>Findings include:<br><br>1.Review of R1's admission Record located in the Profile tab of the electronic medical record (EMR) indicated R1 was admitted to the facility on [DATE] and was discharged on 02/02/26<br><br>Review of R1's discharge assessment Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/02/26 a Brief Interview for Mental Status (BIMS) score of 15 of 15 indicating R1 was cognitively intact. R1 required a wheelchair for ambulation and was independent with most activities of daily living (ADL).<br><br>Review of R2's admission Record located in the Profile tab of the EMR indicated R2 was admitted to the facility on [DATE] with diagnoses of paraplegia and chronic pain. R2 required a wheelchair for ambulation.<br><br>Review of R2's quarterly MDS with an ARD of 03/27/26 revealed that R2 has a BIMS score of 15 of 15, indicating R2 was cognitively intact. The MDS indicated that R2 required the use of a wheelchair for ambulation.<br><br>Review of the Alleged nursing home resident mistreatment, neglect, and abuse report, dated 11/24/25 revealed that [R2] approached [R1] and grabbed [R1] by the shirt flipping him backward out his chair.<br><br>During an interview on 04/28/26 at 1:07 PM, R2 stated he did have an altercation with R1. He stated, I was tired of the way he was talking to everyone. R2 stated he had not gotten into any other altercations before this one.<br><br>During an interview on 04/30/26 at 12:10 PM, Licensed Practical Nurse (LPN) 1 stated she was sitting at the nurses' station when she heard the commotion. She saw R2 put his hand in front of R1's face and then R1 was on the floor. She stated she reported to the Administrator and Social Services Director (SSD), and they started the risk management form. LPN1 stated no other residents witnessed the event.<br>(continued on next page) |

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.

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525371 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/30/2026 |
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| NAME OF PROVIDER OR SUPPLIER Bayshore Nursing & Rehab | | STREET ADDRESS, CITY, STATE, ZIP CODE 1300 West Silver Spring Dr Glendale, WI 53209 | |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 04/30/26 at 12:34 PM, the Administrator stated he and the SSD are both the abuse coordinators in the facility. He confirmed the incident between R2 and R1 did occur. The Administrator stated when the event occurred there were no resident witnesses, just staff. He stated that staff separated the residents and provided supervision.<br><br>2. Review of R9's quarterly MDS with an ARD of 03/27/26 and located under the MDS tab of the EMR revealed R9 was admitted to the facility on [DATE] with diagnoses including non-traumatic brain dysfunction, anxiety and depression. The MDS BIMS score of two out of 15 which indicated R9's cognition was severely impaired.<br><br>Review of R9's Care Plan located under the Care Plan tab of the EMR, revealed a focus area of experienced physical assault placing resident at risk for emotional trauma, fear, behavioral change, initiated on 02/11/26, with a goal to verbalize feeling safe in the facility and not demonstrate trauma related symptoms, and interventions including ensure separation from aggressor, avoid seating placement near triggering individuals and provide staff presence during group activities.<br><br>Review of R9's Interact Change of Condition Evaluation Guide assessment dated [DATE] and located under the Assess tab of the EMR revealed in the summary observations and evaluation dated 02/11/26, Resident was struck with closed fist on right side of face/head by a resident. Swelling redness noted to right head above, and in front of temple area, and under right eye<br><br>Review of the facility Incident Report dated 02/11/26 and provided by the SSD indicated, [R8] became acutely agitated while participating in a supervised group activity with other residents.Staff immediately observed [R8] escalating and positioned themselves between [R8] and R9. A third staff member simultaneously went to remove R8 from the activity to reduce risk of exposure. Despite the staff efforts, [R8] was able to forcefully maneuver past staff and struck R9 once before fully separated. Immediately after the incident R8 was placed on 1:1 supervision, and his psychiatric provider recommended increasing his antipsychotic medication. R8's care plan was revised to include interventions.<br><br>Review of LPN5's witness statement dated 02/11/26 at 9:35 AM revealed, [R9] was sitting at a dining table. [R8] started threatening [R9] with violence. Staff attempted to intervene. [R8] reached up and punched [R9] in the face several times.<br><br>Review of CNA3's witness statement dated 02/11/26 revealed, on 02/11/26 at 9:35 AM, [R9] was sitting across the table from [R8] .[R8] went off on [R9] came around the table where [R9] was and started hitting [R9] in the face [two to three] times.<br><br>Review of Housekeeper (Staff B)'s witness statement revealed, on 2/11/26 at 9:35 AM, [R8] flipped out cursing at [R9] trying to get to [R9] to hit [R8] . [R8] just [kept] on cursing and [hitting] [R9] in the face.<br><br>Review of R8's Care Plan located in the Care Plan tab in the EMR indicated:<br><br>Becomes easily irritated and frustrated when peers joke and make comments toward me, initiated 09/15/25, with a goal to remain free from verbal altercations with peers and interventions including monitor R8's social interactions, provided education on coping strategies and reinforce positive behaviors.<br>(continued on next page) |

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| | 525371 | A. Building<br>B. Wing | 04/30/2026 |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Exhibits impulse-driven behaviors including taking food from peers and when they resist R8 becomes physically aggressive, initiated 11/21/25, with goal to demonstrate improved impulse control and interventions including increased observation during mealtimes, seat resident in a location that minimizes opportunity for taking others, and provide clear, consistent boundaries.<br><br>Repeated involvement with Resident-to-Resident altercations placing self and other at risk for physical injury, initiated 01/15/26, with a goal to remain free from res-to-res altercations and interventions including monitoring R8's behavior, provide seating that minimizes conflict with peers, and redirect R8 away from peers at early signs of agitation.<br><br>During an interview on 04/30/26 at 1:45 PM, with Administrator and SSD, the Administrator indicated there was an incident on 2/11/26 between R9 and R8 in which R8 hit R9 in the face. The SSD stated that since the resident-to-resident altercation on 02/11/26 with R9, R8 had been on 1:1 supervision. R8 was discharged on 04/17/26.<br><br>Review of the facility's undated policy titled Abuse/Neglect/Exploitation provided by the facility revealed. It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure care plans reflected the changing needs of residents to include a plan to maintain communication with family and a plan to be able to volunteer at a soup kitchen for two of 11 sampled residents (Resident (R) 6 and R7) reviewed for care plan revisions. This failure had the potential to cause unmet care needs, distress and a decline in psychosocial well-being.<br><br>Findings include:<br><br>1. Review of R7's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/22/26 and located in the MDS tab of the electronic medical record (EMR), revealed R7 was admitted to the facility on [DATE] with a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating intact cognition. The MDS indicated that R7 did not have behaviors.<br><br>Review of Progress Notes located under the Prog Note tab revealed the following:<br><br>On 10/08/25 at 3:40 PM, Social Service Director (SSD) met with R7 to ensure no negative psychosocial impacts following the incident where R7's family member (FM) A was escorted from the facility by the local police due to suspicion of drug use while in the facility. R7 was calm and verbalized understanding of the situation. SSD encouraged R7 to contact FM A through alternative ways to maintain communication with family.<br><br>Review of the Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report, provided by the facility and the state agency, revealed on 10/08/25, the facility was notified by the state agency that FM A called the state agency to make a report against the DON stemming from an incident the prior day. FM A made physical threats of harm against the DON, as a result the state agency dispatched local police to the building to file formal report.<br><br>Review of R7's Care Plan initiated 08/26/21, last revised 04/25/26, located under the Care Plan tab in the EMR, did not address how R7 was going to maintain communication with FMA, who could not come into the facility.<br><br>During an interview on 04/28/26 at 1:07 PM, R7 said he does have family visit from time to time. R7 said he had no concerns about family visits. When asked about FM A, R7 did not respond.<br><br>During an interview on 04/29/26 at 11:31 AM, the Administrator confirmed that the incidents with FM A and how R7 would communicate with family was not in R7's care plan.<br><br>During an interview on 04/29/26 at 12:12 PM, SSD confirmed that she reviewed R7's care plan and confirmed the care plan did not address how R7 could have communication with FM A<br><br>During an interview on 04/30/26 at 12:50 PM, the Assistant Director of Nursing (ADON) indicated there was an issue with lack of care planning for R7 and how R7 would maintain communication with his family.<br><br>2. Review of R6's quarterly MDS with an ARD of 02/21/26 and located under the MDS tab of the EMR (continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | revealed R6 was admitted to the facility on [DATE] with diagnoses including bipolar disorder and a traumatic brain injury. The MDS revealed a BIMS score of 15 out of 15 which indicated R6's cognition was intact.<br><br>Review of the Elopement Off Premises Report dated 12/12/25 and provided by the Administrator, revealed R6 called a taxicab to take her to a soup kitchen without the guardian's consent.<br><br>Review of R6's Care Plan located under the Care Plan tab of the EMR revealed R6 had a Court Ordered Guardian initiated 07/09/25 and last revised 04/18/26 indicated resident was not permitted to leave the facility independently. R6 was at risk for elopement due to impaired judgment and unsafe decision-making, with the goal of not having any incidents of elopement Since the elopement incident dated 12/12/25, R6's Care Plan did not address that R6's guardian approved for R6's to have planned outings to the soup kitchen and the intervention of the facility escort going with R6 and remaining with R6 while at the soup kitchen.<br><br>During an interview on 04/28/26 at 1:29 PM, R6 indicated the Administrator has made arrangements for her to go to the soup kitchen three times a week.<br><br>During an interview on 04/29/26 at 2:41 PM, SSD said she was not able to find anything in R6's care plan for R6 to go to the soup kitchen and the facility escort to remain with her while on the outing.<br><br>During an interview on 04/30/26 at 12:47 PM, when asked about care planning for R6 and going to the soup kitchen, the ADON confirmed that R6's care plan does not address R6 going on outings to the soup kitchen three times a week with a facility escort. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and policy review, the facility failed to perform medication administration by following accepted standards of identifying the resident prior to administering the medications for one of one resident (Resident (R) 5) reviewed for medication administration in the sample of 11 residents. This failure had the potential to cause decreased quality of life, medication adverse side effects, and exacerbation of health condition.<br><br>Findings include:<br><br>Review of R5's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/30/26 and located in the MDS tab of the electronic medical record (EMR), revealed R5 was admitted on [DATE] with diagnosis of systemic lupus erythematosus (an active chronic autoimmune connective tissue disease. The MD indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating intact cognition. The MDS indicated R5 received scheduled and as needed pain medication for occasional moderate pain.<br><br>Review of R5's Care Plan initiated 11/14/22 and located under the Care Plan tab of the EMR, addressed pain management with a goal to maintain adequate levels of comfort and with interventions including to administer pain medications as ordered.<br><br>Review of the Incidents Log provided by the Administrator indicated a medication error occurred on 02/03/26 for R5.<br><br>Review of the Incident Audit Report dated 02/03/26 and provided by the Administrator, revealed the resident usually received scheduled Oxycodone (narcotic pain medication) 5 milligram (mg) three times daily. The resident was scheduled to receive the Oxycodone at 3:00 AM, however, Licensed Practical Nurse (LPN) 2 (night shift nurse) gave R5 Hydrocodone/APAP (acetaminophen) (Norco, a pain medication combining a narcotic Hydrocodone with a non-narcotic acetaminophen, 5/325 mg) instead. Resident was unaware until notified by the floor nurse.<br><br>Review of the Incident Report revealed it included a statement from LPN2 that indicated on 02/03/26 at 3:00 AM a medication administration error occurred in which R5 was given Norco 5/325 mg instead of Oxycodone 5 mg. The resident was assessed often with no adverse effects observed. Resident does not have an allergy to Norco. Vitals were monitored and were within normal limits. Provider was notified and new orders were for vitals to be taken every shift for 72 hours with continued monitoring for adverse effects. Resident voiced an understanding when notified. The incident report did not reveal the resident had experienced an upset stomach, nausea, and extreme drowsiness for several hours.<br><br>Review of a grievance dated 02/03/26 and provided by the Social Service Director (SSD) that had been filed by R5 indicated, I was given wrong medication on 02/03/26 . Date of occurrence was 02/03/26.<br><br>During an interview on 04/28/26 at 1:14 PM, R5 said on 02/03/26 at 5:13 AM, she received another resident's medication, and stated she usually got medication at that time of day.<br><br>During an interview on 04/29/26 at 5:31 PM, with the Administrator and SSD, the Administrator said<br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | they did a complete investigation into the medication error. The Administrator indicated the medication administration six rights had not been followed.<br><br>Review of the facility's policy titled, Medication Administration dated 2025 and provided by the Administrator documented under the heading Policy Explanation and Compliance Guidelines: 3. Identify resident by photo in the MAR (medication administration record). 10. Ensure that the six rights of medication administration are followed: a. Right resident.<br><br>Review of the facility's policy titled, Medication Errors dated 2025 and provided by the Administrator documented, It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors. The policy defined Medication error as the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order. or accepted professional standards and principles which apply to professional providing services. Under the heading Policy Explanation and Compliance Guidelines indicated, 1. The facility shall ensure medications will be administered as follows: a. According to physician's orders, c. In accordance with accepted standards and principles which apply to professionals providing services. 7. To prevent medication errors and ensure safe medication administration, nurses should verify the following information:.Right resident. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and policy review, the facility failed to implement interventions to prevent elopement of a resident who eloped from the facility without the guardian's approval for one of three sampled residents (Resident (R) 6) reviewed for accident hazards and supervision in the sample of 11 residents. This failure had the potential for impaired judgments and/or unsafe decision making to cause serious harm to the resident. Findings include:Based on record review, interviews, and policy review, the facility failed to implement interventions to prevent elopement of a resident who eloped from the facility without the guardian's approval for one of three sampled residents (Resident (R) 6) reviewed for accident hazards and supervision in the sample of 11 residents. This failure had the potential for impaired judgments and/or unsafe decision making to cause serious harm to the resident.<br><br>Findings include:<br><br>Review of R6's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/21/25 and located in the MDS tab of the electronic medical record (EMR) revealed R6 was admitted to the facility on [DATE] with diagnoses including bipolar disorder and a traumatic brain injury. The MDS revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R6's cognition was intact.<br><br>Review of the Elopement Off Premises Report dated 12/12/25 and provided by the Administrator revealed R6 called a taxicab to take her to a soup kitchen without her guardian's consent. R6 said she was going to the store. The taxicab company was called for the location of where R6 was dropped off. Facility staff went to the location to bring R6 back to the facility.<br><br>Review of R6's Care Plan located under the Care Plan tab of the EMR revealed R6 had a Court Ordered Guardian and was not permitted to leave the facility independently, initiated 07/09/25. R6 was at risk for elopement due to impaired judgment and unsafe decision- The goal indicated that the resident would not have any incidents of elopement. Interventions included hourly checks, initiated 08/15/25; all exits of the building required a staff escort and prior guardian approval, initiated 12/12/25.<br><br>Review of Progress Notes located under the Progress Note tab of the EMR revealed the following:<br><br>On 08/30/24 at 9:42 PM (date of admission), R6 had a history of elopement while at home.<br><br>On 12/12/25 at 9:39 AM, Social Service Director (SSD) notified that R6 had left the facility without supervision and without the permission of the court appointed guardian. Facility conducted thorough search of building, but the resident was not located. SSD notified the guardian. Staff were dispersed throughout the surrounding neighborhood and nearby stores. Local police were also notified. During the investigation, it was identified that the resident had been observed leaving the facility via Yellow Cab taxi. Yellow Cab was contacted and drop-off location was obtained. Local police escorted SSD to the identified address. R6 was located at the address volunteering. R6 was appropriately dressed for the weather and situation. R6 said she was safe and had already coordinated transportation back to the facility. The psychiatric physician was notified of the elopement. R6 returned to the facility safely. Ongoing monitoring, care plan review, and interdisciplinary follow-up to address elopement risk would continue.<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Progress Notes in the EMR under Progress Notes tab revealed that on 12/12/25 at 11:01 AM, Licensed Practical Nurse (LPN) 3 made a late entry: Writer arrived to work at 7:25 AM. R6 was standing in the entrance way and doorway of the building. When writer entered building, asked R6 where she was going. Appointment this early? R6 said, I'm going to the store and asked if I had any change. Writer said no, but needed to clock in because of being late, and would come back. Writer also asked Administrator and Director of Nursing (DON) for change. DON asked writer where R6 was going, and the writer said to the store. The DON said by herself, and the writer said yes, R6 said she is coming right back. Writer asked DON if R6 had signed out. They both looked in the book, and said no. Writer asked if she should chart or sign R6 out, and the DON said tell the SSD about it. It was not until the writer was approached by one of the social workers that was informed that R6 eloped because no one knew where R6 was. Writer told the social worker about the morning activities and was informed to speak to SSD.<br><br>On 12/15/25 at 9:14 AM, noted on 12/15/25, R6 was observed manic and exhibiting increased agitation, exit seeking behaviors and combative behaviors both verbally and physically. R6 became upset regarding the desire to have breakfast with a friend. R6 said she had contacted the guardian 72 hours in advance, per guardian request, to obtain permission for an outing, but the guardian had not responded.<br><br>On 12/15/25 at 2:00 PM, revealed nursing staff brought R6 to SSD due to exit-seeking behaviors and attempted to leave the facility unsupervised. SSD met with R6 who was observed to be anxious and expressing a desire to leave the facility. SSD provided redirection and R6 was able to engage in appropriate conversation. SSD reviewed the process for requesting outings and assisted R6 with submitting a request. R6 remained in the building, and no further exit seeking was observed at the conclusion of the encounter.<br><br>During an interview on 04/28/26 at 1:29 PM, R6 indicated the Administrator had made arrangements for her to go to the soup kitchen three times a week.<br><br>During an interview on 04/29/26 at 2:41 PM, SSD said after R6 went under guardianship she indicated she would act out because of the guardianship. SSD said she was not able to find anything in the care plan specifically for going to the soup kitchen and the circumstances when she does have permission to go out.<br><br>During an interview on 04/30/26 at 12:47 PM, when asked about care planning for R6 and going to the soup kitchen, Assistant Director of Nursing (ADON) indicated it was not written in the care plan.<br><br>During an interview on 04/30/26 at 4:48 PM, with the Administrator and SSD, SSD said R6 was first on 1:1s after the elopement on 12/12/25, then on 15-minutes checks and then at the time of the 12/12/25 elopement was on hourly checks. The facility became aware that she was gone and getting into a cab because of the hourly checks. At 4:57 PM, the Administrator showed a video of R6 standing in the doorway and leaving the building.<br><br>During an interview on 04/30/26 at 6:30 PM, LPN3 said she had training on elopements and wander guards upon hire and after R6 eloped.<br><br>During an interview on 04/30/26 at 6:35 PM, the Administrator said staff had elopement training in July and then after R6's elopement in December 2025. The Administrator said after the guardian agreed R6 could go to the soup kitchen three times a week, the facility agreed to provide the<br>(continued on next page) |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | transportation and supervision while the resident was at the soup kitchen.<br><br>During an interview on 04/30/26 at 6:50 PM, Staff A said he went to the food pantry on Monday, Wednesday and Friday and was R6's escort. He stated that he stayed with her while she was there and returned with her to the facility.<br><br>Review of the facility's undated policy titled, Elopement provided by the Administrator indicated, This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk.<br><br>Review of the facility's undated policy titled, Policy Explanation and Compliance Guidelines the policy indicated .3. The facility is equipped with door locks/alarms to help avoid elopements. 4. Alarms are not a replacement for necessary supervision.6. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering: b. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. d. Adequate supervision will be provided to help prevent accidents or elopements. e. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions and document accordingly. 7. Procedure for Locating Missing Resident: a. Any staff member becoming aware of a missing resident will alert personnel using facility approved protocol (e.g., internal alert code). b. The designated facility staff will look for the resident.8. Procedure Post-Elopement: d. The resident and family/authorized representative will be included in the plan of care. |