

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017746	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/06/2022
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NAME OF PROVIDER OR SUPPLIER OAK PARK PLACE OF OAK CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 1980 W RAWSON AVE OAK CREEK, WI 53154
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N 000	Initial Comments On 05/03/2022, Surveyors completed 3 complaint investigations. As a result, 5 deficient practices were identified and 3 complaints were substantiated. Census: 35	N 000		
N 163	83.12(4)(a) Reporting when resident's whereabouts unknown A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time a resident ' s whereabouts are unknown, except those instances when a resident who is competent chooses not to disclose his or her whereabouts or location to the CBRF, the CBRF shall notify the local law enforcement authority immediately upon discovering that a resident is missing. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies or persons recovering from substance abuse. This Rule is not met as evidenced by: Based on record review and interview, the provider did not submit a written report to the department within 3 working days after an elopement for 1 of 1 resident. Resident 2 eloped from the facility on 09/15/2021. Findings include: On 04/12/2022, Surveyor reviewed Resident 2's record and identified the following: Resident 2 was admitted on 09/07/2021, with diagnoses including dementia, anemia, hypertension, type 2 diabetes mellitus, coronary	N 163		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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N 163	<p>Continued From page 1</p> <p>artery disease and hearing loss.</p> <p>Resident 2's individual service plan (ISP), dated 09/07/2021, identified Resident 2 was an elopement risk.</p> <p>Resident 2's incident report, dated 09/15/2021, stated, "A passer-by on Rawson Ave [Avenue] called the building to inform they believe one of our residents was wandering." The report indicated staff left the building and brought Resident 2 back.</p> <p>Resident 2's progress note dated 09/15/2021, at 5:57 PM, indicated Resident 2 was unharmed and safe. Staff would conduct 30-minute checks and more frequently if able.</p> <p>On 04/13/2022, Surveyor reviewed the provider's self-report history. The department did not receive a self-report when Resident 2 eloped from the facility on 09/15/2021.</p> <p>On 05/03/2022, at 2:30 PM, Surveyors interviewed Director of Housing (DOH) A. DOH A reported s/he was aware of the reporting requirements and would ensure reports were sent in as required. DOH A was not employed with the provider at the time of elopement.</p>	N 163		
N 165	<p>83.12(4)(c) Reporting incidents with serious injury</p> <p>A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident.</p>	N 165		

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N 165	<p>Continued From page 2</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the provider did not notify the department within 3 working days of a serious injury requiring hospitalization for 1 of 1 resident reviewed. Resident 6 had a fall on 03/22/2022, resulting in a fractured hip which required hospitalization.</p> <p>Findings include:</p> <p>On 04/12/2022, Surveyor reviewed Resident 6's record and identified the following:</p> <p>Resident 6 was admitted to the facility on 08/31/2020.</p> <p>Resident 6's facility incident report, dated 03/22/2022, identified Resident 6 had an unwitnessed fall. Further review identified "resident was found on the floor in front of [her/his] wheelchair." Resident 6 was transported to the hospital and diagnosed with a right fractured hip.</p> <p>Resident 6's facility progress note, dated 03/22/2022, identified "resident was found on floor in front of [her/his] wheelchair, laying on right side." Right leg was bent and externally rotated, complained of severe pain. Resident 6 was sent to the hospital for evaluation.</p> <p>On 04/13/2022, Surveyor reviewed the provider's self-report history. The department did not receive a self-report for Resident 6's fall on 03/22/2022, which resulted in a hospitalization.</p> <p>On 05/03/2022, at 2:30 PM, Surveyors interviewed Director of Housing (DOH) A. DOH A</p>	N 165		

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N 165	Continued From page 3 reported s/he was aware of the reporting requirements and was not employed by the provider at the time of the incident. DOH A reported s/he would ensure reports were sent in as required.	N 165		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure there was a sufficient number of staff on a 24-hour basis to meet the needs of 5 of 5 residents (Resident 1, Resident 3, Resident 4, Resident 5 and Resident 6) as it pertained to: showering, toileting, transferring assistance, housekeeping, and timely response to residents requesting assistance (through the call light system). The facility is a Class CNA (non-ambulatory) Community-Based Residential Facility (CBRF), licensed to serve up to 90 residents who may be of advanced age and/or irreversible dementia/Alzheimer's disease. There is a secured memory care unit within the facility which serves residents in need of increased supervision associated with dementia related illness. Findings include: On 02/21/2022, and 02/22/2022, the department received 2 complaints alleging lack of staff caused long wait times and cares were not provided to residents.	N 396		

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N 396	<p>Continued From page 4</p> <p>On 04/12/2022, between 9:15 AM and 12:15 PM, Surveyors toured the facility. The facility was a 2 story, expansive building. The lower level consisted of a designated memory care unit with 40 residential rooms. The main level consisted of 3 corridors, which resembled a backwards letter F and contained 40 residential rooms.</p> <p>Staff Interview: On 04/13/2022, at 9:30 AM, Surveyors interviewed Caregiver C regarding resident cares and staffing. Caregiver C reported 1st shift was 6:00 AM until 2:30 PM, 2nd shift was 2:00 PM until 10:30 PM and 3rd shift was 10:00 PM until 6:30 AM. Caregiver C reported 1st and 2nd shift typically had 4 staff with 2 staff per level and 3rd shift had 3 staff, with 1 staff floating between the 2 levels. Caregiver C stated, "It's supposed to be 2 up and 2 down, but we work short staffed." Caregiver C reported staff were responsible for assisting with residents' personal cares, housekeeping of the resident rooms and units, laundry, passing out meals and medication administration. Caregiver C reported at least 4 residents required Hoyer transfers (mechanical lifts), which required 2 staff per provider policy. Caregiver C reported the provider's policy for answering resident's call lights was within 15 minutes. Caregiver C reported some residents' cares and transfers, those with Hoyer lifts, take longer than 15 minutes. Caregiver C stated, "[Resident 1] takes 45 minutes in the morning. They expect us to start with [Resident 1] and answer call lights too. [Resident 1's] a Hoyer lift."</p> <p>On 04/12/2022, at 9:40 AM, Surveyors interviewed Caregiver D. Caregiver D reported s/he worked various shifts. Caregiver D stated, "We're always short staffed." Caregiver D</p>	N 396		

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N 396	<p>Continued From page 5</p> <p>reported on shower days, residents were to have their rooms cleaned, vacuumed and laundry completed. Caregiver D stated, "We don't have time." Caregiver D reported Resident 1 typically required 45 minutes in the morning. Caregiver D reported Resident 1 was transferred via a Hoyer lift and required 2 staff to transfer. Caregiver D stated, "They want us to stop what we're doing and answer [the lights]. [Residents] are already wet by the time we get there. It happens frequently."</p> <p>Caregiver D reported there were currently 4 residents which required transferring via a Hoyer lift.</p> <p>On 04/12/2022, at 10:10 AM, Surveyors interviewed Caregiver E regarding residents not receiving showers. Caregiver E stated, "It really comes down to staffing. We don't have enough staff."</p> <p>Resident Record Review and Interview:</p> <p>Resident 1 Resident 1 was admitted on 04/28/2021. Resident 1's individual service plan (ISP) dated 08/05/2021, indicated Resident 1 required staff assistance with showering, dressing, housekeeping and laundry. Resident 1 required staff assistance of 2 with toileting and transfers via a mechanical lift. Resident 1's resident evacuation assessment, dated 12/27/2021, identified Resident 1 required full assistance from 2 staff for evacuation.</p> <p>On 04/12/2022, at 10:05 AM, Surveyors interviewed Resident 1. Resident 1 reported it often took at least half an hour or longer, for staff to respond to her/his call light. Resident 1 reported her/his room was not cleaned weekly,</p>	N 396		

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N 396	<p>Continued From page 6</p> <p>s/he did not receive weekly showers, and waited long periods for staff to transfer her/him. Resident 1 required staff assistance with Hoyer transfers. Resident 1 reported s/he was supposed to receive a shower twice per week; however, s/he did not. Resident 1 obtained a notepad and reported the following dates of when s/he received a shower: 05/13/2021, 07/09/2021, 08/06/2021, 08/31/2021, 09/14/2021, 11/06/2021, 11/09/2021, 11/30/2021, 12/28/2021, and 01/12/2022. Resident 1 stated, "They aren't living up to what they said." Resident 1 reported staff state, "We don't have the time." Resident 1 reported her/his room was not cleaned weekly, and the bedding had not been cleaned since December 2021. Resident 1 reported s/he had verbalized her/his concerns to Regional Director of Housing (RDoH) B and there was no change. Resident 1 stated, "If you have a problem, you're out of luck." Resident 1 reported most times there was 1 caregiver per floor. Resident 1 reported s/he experienced times when the caregiver from the secured memory care unit on the lower level, would not come up to help the caregiver transfer her/him. Resident 1 reported s/he had called the police department 3 times for assistance with transfers. Resident 1 stated, "I had to sit in my wheelchair." Resident 1 reported her/his sores were worse due to not being repositioned.</p> <p>On 04/15/2022, at 11:20 AM, Surveyor spoke with Home Health Nurse (HHRN) F. HHRN F reported s/he provided wound care treatment to Resident 1. HHRN F reported Resident 1 had excoriated areas in the right and left abdominal folds. HHRN F reported the buttock area was larger. HHRN F stated, "The [wound] has deteriorated. I don't think they reposition [Resident 1] ...They are chronically short staffed."</p>	N 396		

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N 396	<p>Continued From page 7</p> <p>On 04/20/2022, Surveyor received and reviewed home health nursing notes. HHRN F's nursing note, dated 02/24/2022, indicated a previously closed wound had reopened and measured 2.5 centimeters (CM) X 1.3 CM X 0.3 CM. In the narrative section, HHRN F stated, "During this visit and previous visits no nurse has been found in the facility and as of this day (02/24/2022) [RDoH B] has not returned any phone calls."</p> <p>HHRN F's nursing note, dated 03/10/2022, indicated the wound was 2.8 CM X 1.5 CM X 0.3 CM.</p> <p>HHRN F's nursing note, dated 03/17/2022, indicated the wound was 3.1 CM X 1.8 CM X 0.5 CM.</p> <p>HHRN F's nursing note, dated 03/29/2022, indicated the wound was 3.5 CM X 2.0 CM X 0.2 CM.</p> <p>Resident 3 Resident 3 was admitted on 05/28/2021. Resident 3's ISP, dated 08/05/2021, indicated Resident 3 required staff assistance with showering, dressing, toileting, transferring, housekeeping and laundry.</p> <p>On 04/12/2022, 10:40 AM, Surveyors interviewed Resident 3. Resident 3 reported s/he frequently waited long periods of time for staff to respond to her/his call light. Resident 3 reported the facility did not have enough staff. Resident 3 stated, "They didn't come, I pushed it again, it was close to 30 minutes." Resident 3 stated, "They're spread too thin." Resident 3 reported her/his bedding was changed "a handful of times" since her/his admission. Resident 3 stated, "I thought it was supposed to be weekly." Resident 3 reported staff didn't have time to clean the bathroom or living area, stating "I can't blame [her/him]. [S/he]</p>	N 396		

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N 396	<p>Continued From page 8</p> <p>was busy." Resident 3 reported s/he spoke with RDoH B regarding the lack of services, stating, "I talked to [her/him], I don't know how many times. It falls on deaf ears." Resident 3 reported s/he required assistance with transfers. Resident 3 stated one time s/he transferred herself/himself.</p> <p>Resident 6 Resident 6 was admitted on 08/31/2020. Resident 6's ISP, dated 08/05/2021, indicated Resident 6 required staff assistance with showering, dressing, toileting, transferring, housekeeping and laundry.</p> <p>On 04/12/2022, 11:15 AM, Surveyors interviewed Resident 6. Resident 6 reported s/he did not receive weekly showers. Resident 6 stated, "Showers seem to be a problem ...They don't have enough staff." When Surveyors inquired what not having enough staff looked like, Resident 6 stated, "Long wait times, things you want done isn't done, a lot of times it's only 1 person for all the people. I feel like I don't get a chance to get clean, like they're rushing me. I would like to get a sponge bath, they can't. They don't have time."</p> <p>Resident 4 Resident 4 was admitted on 02/13/2022. Resident 4's ISP, dated 02/13/2022, indicated Resident 4 required staff assistance with housekeeping and laundry.</p> <p>On 04/12/2022, at 10:30 AM, Surveyors interviewed Resident 4. Resident 4 reported staff are supposed to clean the bathroom and living area weekly, "but it never gets done." Resident 4 reported at times staff will clean parts of the bathroom. Resident 4 reported s/he had to request staff to vacuum. Resident 4 stated, "I</p>	N 396		

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N 396	<p>Continued From page 9</p> <p>asked for it to be done, but they only vacuumed the living area, not the bedrooms. They never quite get the whole place clean...I do more work here than I did at home."</p> <p>Resident 5 Resident 5 was admitted on 09/01/2020. Resident 5's ISP, dated 08/05/2021, indicated Resident 5 required staff assistance with showering, dressing, toileting, transferring, housekeeping and laundry.</p> <p>On 04/13/2022, at 10:15 AM, Surveyors interviewed Resident 5. Resident 5 reported s/he had long wait times for staff to respond to her/his call light. Resident 5 reported her/his room was not cleaned on a weekly basis. Resident 5 stated, "They're supposed to do it once a week." Resident 5 retrieved a writing pad with documented dates of when staff vacuumed her/his room. Resident 5 reported staff vacuumed on 12/13/2021, 01/17/2022, and 03/17/2022. Resident 5 reported her/his bathroom was cleaned on 12/15/2021, 01/17/2022, 02/07/2022, 02/28/2022, 03/21/2022 and 04/04/2022. Resident 5 reported s/he spoke with RDoH B and stated, "[RDoH B] doesn't address complaints."</p> <p>Call Light Log Record: On 04/12/2022, Surveyors reviewed Resident 1's, Resident 3's, Resident 4's, Resident 5's and Resident 6's call light logs between 01/01/2022-04/12/2022. In review, Surveyors observed approximately 136 call light wait times of 15 minutes or greater. The 3 longest wait times were 97 minutes, 35 seconds for Resident 1, 193 minutes, 03 seconds for Resident 3 and 202 minutes, 09 seconds for Resident 6.</p> <p>Facility Program Statement:</p>	N 396		

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N 396	Continued From page 10 The providers program statement stated, "Resident room housekeeping will be done on a weekly basis (more if necessary)." On 05/03/2022, at 2:30 PM, Surveyors interviewed Director of Housing (DOH) A and Regional Nurse (RN) G. DOH A reported s/he could not speak to staffing prior to her/his employment but was working on staffing. RN G reported there was a change in the leadership and the provider was implementing structure to provide direction and guidance for staff.	N 396		
N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 2 of 2 residents who self-administered medications, were provided a system to securely store their medications. Resident 3's medications were stored on the table next to the chair in the living area and in an unlocked cabinet above the kitchenette sink. Resident 4's medications were stored on the kitchenette counter and in the cabinet above the kitchenette sink and in the bathroom closet. Findings include: On 04/12/2022, between 9:30 AM and 11:00 AM, Surveyors observed the following: -Resident 3's medications were not securely stored. Resident 3's medication boxes were stored on a tiered table in the living area.	N 419		

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N 419	<p>Continued From page 11</p> <p>Medication bottles were stored in an unlocked cabinet above the kitchenette sink in Resident 3's room. The following unsecured medications observed in Resident 3's room were carbidopa-levodopa 25-100 milligrams (mg), fluoxetine 10 mg, metoprolol tartrate 25 mg, pantoprazole 40 mg, raloxifene hydrochloride 60 mg, potassium chloride 20 milliequivalent (mEq), mesalamine 1.2 gram, Lasix 20 mg, baclofen 5 mg, tramadol 50 mg, fiorcet 50-325 mg, Zofran 8 mg, and flecainide acetate.</p> <p>-Resident 4's medications were not securely stored. The medications were stored on the kitchenette counter, in a cabinet above the kitchenette sink and in the bathroom closet. The following unsecured medications observed in Resident 4's room were cephalexin 500 mg, furosemide 20 mg, potassium chloride 10 mEq, diclofenac 1% gel, gabapentin 300 mg, acetaminophen 500 mg, albuterol 108, Aleve 220 mg, aspirin 81 mg, atorvastatin 10 mg, carbidopa-levodopa 25-100 mg, levothyroxine 88 micrograms (mcg), lisinopril 10 mg, loperamide HCL, metronidazole 1% gel, pantoprazole 40 mg, cranberry 500 mg, vitamin B-12 1000 mcg, and vitamin d3 25 mcg.</p> <p>Residents were observed moving freely throughout the facility.</p> <p>On 04/12/2022, at 2:00 PM, Surveyors interviewed Director of Housing (DOH) A regarding the unsecured medications. DOH A reported Resident 3 and Resident 4's medications were not securely stored. DOH A confirmed s/he was aware of the requirement to securely store all medications and stated, "I'm buying some lock boxes today."</p>	N 419		

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NAME OF PROVIDER OR SUPPLIER OAK PARK PLACE OF OAK CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 1980 W RAWSON AVE OAK CREEK, WI 53154
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 426 N 426	<p>Continued From page 12</p> <p>83.38(1)(b) Supervision.</p> <p>As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Supervision. The CBRF shall provide supervision appropriate to the resident's needs.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident (Resident 2) received supervision appropriate to her/his needs. Resident 2 eloped from the secured memory care unit and was found on the road by a passerby, who notified the facility staff Resident 2 was wandering.</p> <p>The facility is licensed to serve advanced aged and irreversible dementia/Alzheimer's residents.</p> <p>Findings include:</p> <p>03/08/2022, the department received a complaint regarding the elopement of a resident on 09/15/2021.</p> <p>On 04/12/2022, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 09/07/2021, with diagnoses including dementia, anemia, hypertension, type 2 diabetes mellitus, coronary artery disease and hearing loss.</p>	N 426 N 426		

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N 426	<p>Continued From page 13</p> <p>Resident 2's comprehensive assessment, dated 09/07/2021, indicated Resident 2 was frequently disoriented to person, place and time and was an elopement risk.</p> <p>Resident 2's temporary individual service plan (ISP), dated 09/07/2021, identified Resident 2 as an elopement risk. Resident 2's temporary ISP did not include any behavioral interventions or change in the level of supervision to reflect the immediate needs of Resident 2 after s/he eloped from the facility.</p> <p>On 09/12/2021, 30-minute checks were implemented using a form titled, "30 Minute Checks."</p> <p>On 09/12/2021, Resident 2's 30-minute checks form did not verify Resident 2 was checked on by staff at 2:30 PM, and between 3:30 PM and 11:30 PM.</p> <p>On 09/13/2021, Resident 2's 30-minute checks form did not verify Resident 2 was checked on by staff between 2:30 PM and 6:30 PM and again between 9:30 PM and 10:30 PM.</p> <p>On 09/14/2021, Resident 2's 30-minute checks form did not verify Resident 2 was checked on by staff at 1:00 PM and 1:30 PM. The comment section, located at the bottom of the form, stated, "Watch out for [her/his] mood swings. 2nd shift-resident kept trying to swing [at] staff."</p> <p>On 09/15/2021, at 3:30 PM, staff indicated Resident 2 was seen in the TV room. At 4:00 PM and 4:30 PM, it was documented "N/A." The comment section, located at the bottom of the form, stated, "Got out of building between 4/430 pm."</p>	N 426		

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N 426	<p>Continued From page 14</p> <p>Resident 2's incident report, dated 09/15/2021, stated, "A passer-by on Rawson Ave [Avenue] called the building to inform they believe one of our residents was wandering." The report indicated staff left the building and returned Resident 2 to the facility. The incident report stated, "Unsure of how resident eloped with alarms sounding."</p> <p>Resident 2's progress note dated 09/15/2021, at 17:57 (5:57 PM), stated, "[Resident 2] is unharmed and currently safe." Resident 2's progress note indicated staff would "continue 30-minute checks and more frequently if able."</p> <p>Resident 2's ISP was not updated with any new behavioral interventions or change in the level of supervision.</p> <p>On 09/16/2021, Resident 2's 30-minute checks did not verify Resident 2 was checked on between 12:00 AM and 2:00 PM and again at 10:30 PM.</p> <p>On 09/17/2021, Resident 2's 30-minute checks form indicated Resident 2 received 1:1 supervision from staff between 12:00 AM and 5:30 AM. There was no further documentation verifying Resident 2 was checked on between 6:30 AM and 10:30 PM.</p> <p>On 09/18/2021, Resident 2's 30-minute checks form did not verify Resident 2 was checked on by staff between 6:30 AM and 2:00 PM. The comment section stated, "Resident was found in another resident's bed [at] 10:30 PM and became combative."</p> <p>On 09/19/2021, Resident 2's 30-minute checks form did not verify Resident 2 was checked on by</p>	N 426		

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N 426	<p>Continued From page 15</p> <p>staff between 12:00 AM and 5:30 AM and again from 3:30 PM through 10:30 PM.</p> <p>There were no 30-minute check forms or documentation verifying Resident 2 was checked on by staff on 09/20/2021 and 09/21/2021.</p> <p>On 09/22/2021, Resident 2's 30-minute checks form did not verify Resident 2 was checked on by staff between 6:30 AM and 10:30 PM.</p> <p>There were no 30-minute checks forms or documentation verifying Resident 2 was checked on by staff on 09/23/2021, 09/24/2021, 09/25/2021, 09/26/2021, 09/27/2021, and 09/28/2021.</p> <p>On 09/29/2021, Resident 2's 30-minute checks form did not verify Resident 2 was checked on by staff after 4:30 PM.</p> <p>On 04/12/2022, between 9:30 AM and 2:00 PM, Surveyors interviewed Caregiver C, Caregiver D and Caregiver E regarding Resident 2's elopement. Caregiver C and Caregiver D confirmed Resident 2 was an elopement risk. Caregiver E reported Resident 2 was "always antsy, walking back and forth."</p> <p>On 05/03/2022, at 2:30 PM, Surveyors interviewed Director of Housing (DOH) A and Regional Nurse G. DOH A reported s/he was not an employee at the time of Resident 2's elopement and could not speak to Resident 2's supervision needs from that time. Regional Nurse G reported staff may have utilized other means of documenting observations; however, was unable to provide any other documentation verifying staff conducted the 30-minute checks.</p>	N 426		