STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155432	A. BUILDING 00 B. WING	09/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY HEALTH CARE & REHABILITATION CENTER	910 W WALNUT ST ALBANY, IN 47320

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00360529 and IN00361477. This visit resulted in a Partially Extended Survey-Substandard Quality of Care - Immediate Jeopardy. Complaint IN00360529 - Unsubstantiated due to lack of evidence. Complaint IN00361477 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677, F609 and F689. Survey dates: September 8 and 9, 2021. Facility number: 000309 Provider number: 155432 AIM number: 100288960 Census Bed Type: SNF/NF: 72 Total: 72 Census Payor Type: Medicare: 9 Medicaid: 52 Other:11 Total: 72 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 16, 2021.	F 0000	This plan of correction is prepared and executed because it is required by the provisions of state and federal law, and not because Albany Health and Rehab agrees with the allegations contained therein. Albany Health and Rehab maintains that each deficiency does not jeopardize the health and safety of the residents, nor is it of such character as to limit our capacity to render adequate care. Please let this Plan of Correction serve as the facility's credible allegation of compliance for the date of 9/28/2021. Albany Health and Rehab respectfully requests paper compliance.	
F 0609 SS=D	483.12(c)(1)(4) Reporting of Alleged Violations			

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

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Bldg. 00	§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review and interview, the facility failed to report to the State Agency an incident of elopement for 1 of 3 residents reviewed for elopement (Resident B). Findings include: Resident B's clinical record was reviewed on 9/8/21 at 10:27 a.m. Diagnoses included, but were not limited to, cellulitis, dementia without	F 0609	**Immediate Jeopardy POC** F689/ F609 Called 9/8/2021 Albany Health & Rehabilitation Center 1. **What corrective action(s) will be accomplished for those residents found to have been**	09/28/2021

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	behavioral disturbance, essential (primary) hypertension, edema, muscle weakness (generalized), need for assistance with personal care, cognitive communication deficit and anxiety disorder. An admission Minimum Data Set (MDS), dated 8/16/21, indicated she was severely cognitively impaired. The clinical record lacked any indication of the elopement. During an initial tour of the facility, on 9/8/21 at 9:52 a.m., the ADON indicated there had been no elopements in the last couple months in the memory care unit. During an interview with RN 15, on 9/8/21 at 11:20 a.m., she indicated she had heard Resident B had eloped from the building on a Sunday, two to three weeks ago. The resident exited the memory care unit. The door alarm had not worked and a new door alarm was installed. Resident B hit the door handle multiple times and shook the door and the door opened for her. Resident B walked outside, which was a fenced in area with three gates. The one gate was unlocked near the 100 hall entrance and thought she got out to the employee parking lot through the unlocked gate. She was found in the front yard or at the front of the building by the DON. They tried as much as possible to keep the residents in the area they were working in and tried to watch the halls also. Sometimes they would entertain the residents at the door if they were exit seeking, like they looked for a squirrel. She felt the resident was now getting acclimated to the facility since she was a newer admission.		**affected by the deficient practice.** Resident was safely returned to the secured Memory Care Unit within 15 minutes of exiting the unit. Resident was immediately assessed and found to have no signs of physical injury and showed no signs of mental anguish. The incident was reported to the Department of Health on the Gateway system as an unusual occurrence by the Director of Clinical Services. (incident number 206) 2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents residing on the Memory Care unit could be at risk. The Facility completed an audit of all incidents that occurred within the last 30 days to see if any incidents met the criteria for reporting the incident to the State Agency. No additional incidents were identified that met the requirements for self-reporting. Elopement Risk Assessments were updated on all residents and Care Plans with appropriate interventions were updated as needed. Elopement Binders were	

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	During an interview, on 9/8/21 at 12:27 p.m., with the Administrator and with DON, ADON, Nurse Consultant present, she indicated Resident B had followed a staff member out of the memory care door. CNA 26 had gone outside to the garage to gather supplies and take out the trash. Resident B got out while the door was unlocked from CNA 26 exiting the door, she wasn't sure what time of day it was but it was early afternoon on 8/22/21. The nurse that was working found the resident outside. The DON indicated she drove by and saw someone outside and called LPN 21 to check. The resident walked out after CNA 26 went to the garage and the resident walked passed the garage and around to the front of the building. The gate was normally locked. The DON indicated LPN 21 was instructed to do a head to toe assessment on the resident when she brought her back into the facility. Corporate had came in the next day to look at the alarm on the door and put a new siren on it. Administrator indicated they had not reported the elopement to the State Agency. A current facility policy, titled "Administrative - Accidents and Incidents investigating and reporting," provided by the DON, on 9/9/21 at 3:49 p.m., indicated the following: "Purpose: To ensure that reportable occurrences are recorded and monitored to facilitate compliance with the state and federal laws...The following are examples of occurrences that the Long Term Care Division considers reportable under State Rules Only. These occurrences will be reported by the facility and will be tracked and monitored. 1. Occurrence that directly threatens the welfare, safety or health of a resident...Elopement of a resident with cognitive deficits who was found outside the facility and whose whereabouts had been unknown or whose return involves law		reviewed and found to be current to include all residents found to be at risk for elopement. 3. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Any resident upon admission or re-admission or re-admission to the facility, will have an elopement risk assessment completed and appropriate care planning will be completed. An elopement in-service was conducted for staff on 8/23/21, to include education on elopement risk and maintaining a safe environment by ensure doors are secured to prevent elopement. While the exit door located on the Memory Care Unit seemed to be functioning properly, the door was supplied with a new keypad, power supply and loud horn on 8/31/21 to ensure and extra layer of security. The exit doors are on the TELS Preventative Maintenance schedule and are checked weekly by the Director of Plant Operations to ensure that they are working properly. The Administrator and the Director of Clinical Services were reeducated on the policy and Guidelines for Reporting Unusual Occurrences to the IDOH.	

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	enforcement...." This Federal tag relates to Complaint IN00361477. 3.1-28(c)		The Director of Clinical Services or Designee will review incidents during the daily clinical meeting for 6 months and until 100% compliance is maintained The monthly QAPI meetings will include review of all incidents to ensure that unusual occurrences that meet the criteria for reporting to the State Agency are reported timely. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** The Director of Plant Operations will audit and inspect all exit doors on a weekly basis with supporting documentation in the TELS Monitoring system, all concerns and findings will be forwarded by the Director of Plan Operations to the Health Facility Administrator and the QAA committee for further response and monitoring. The Administrator of her designee will audit all new admissions and all re-admissions to ensure that an Elopement Risk Assessment was completed for 4 weeks and until 100% compliance; and then 5 admissions or readmissions per month for 6 months and until 100% compliance is maintained to ensure Elopement Risk Assessments are completed. The Director of Clinical Services	

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			or Designee will review incidents daily during the clinical meeting for 6 months and until 100% compliance is maintained. The monthly QAPI meetings will include review of all incidents to ensure that unusual occurrences that meeting the criteria for reporting to the State Agency are reported timely. Administrator and Director of Clinical Services were reeducated on the Policy and Guidelines for reporting Unusual Occurrences. 5. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** It is important to note that the above corrective measures were completed prior to 9/8/2021 when the Immediate Jeopardy notification was made.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to			

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	carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on interview and record review, the facility failed to ensure showers were provided for dependent residents, per care planned preferences, for 2 of 3 residents reviewed for ADL's (Activities of Daily Living) (Resident's C and D). Findings include: 1. Resident C's clinical record was reviewed on 9/9/21 at 9:39 a.m., Diagnoses included, but were not limited to, Alzheimer's disease and Parkinson's disease. A 7/12/21 quarterly MDS (Minimum Data Set) assessment indicated she had severe cognitive impairment. She required extensive assistance of two persons with bed mobility, transfers, to walk in the room and in the corridor, locomotion on and off the unit, dressing, toilet use, and personal hygiene. A current care plan, dated 1/12/15, indicated she had specific choices. Interventions included, but were not limited to, she preferred to have showers. A current care plan, dated 2/11/15, indicated she needed assistance with ADL's related to dementia. Interventions included, but were not limited to, she needed total assistance with bathing. Review of showers and bathing from 8/24/21 through 9/8/21 indicated she had received a bed bath on 8/24/21, 8/31/21, 9/4/21 and 9/7/21. She	F 0677	**Shower/ADL – F677** **Plan of Correction** **1. What corrective action(s) will be accomplished for those found to have been affected by the deficient practice?** Residents were provided shower. Resident C was in agreement with being provided bed baths related to droplet isolation/possible exposure to COVID-19. Any resident choosing to have shower instead of bed bath who is in droplet isolation was being provided a shower. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents shower schedules and preferences reviewed to ensure choices accuracy. Inservicing for staff regarding bathing choices and documentation. **3. What measures will be put into place or what systemic**	09/28/2021

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	had not received any showers during that time frame. A shower schedule, provided by the DON on 9/9/21 at 1100 a.m., indicated the resident was scheduled to receive a shower Tuesday and Saturday evenings. B. Resident D's clinical record was reviewed on 9/9/21 at 10:46 a.m. Diagnoses included, but were not limited to, cognitive communication deficit, weakness and need for assistance with personal care. An 8/21/21 admission MDS assessment indicated she was cognitively intact. She required limited assistance of two persons with transfers, to walk in the room and in the corridor, extensive assistance of one person with bed mobility, dressing, and personal hygiene, and extensive assistance of two persons with toileting. Bathing had not occurred. A current care plan, dated 8/26/21, indicated she had specific choices. Interventions included, but were not limited to, she preferred to have showers twice a week after breakfast. Review of showers and bathing from 8/24/21 through 9/8/21 indicated she had a shower on 8/24/21. A shower schedule, provided by the DON on 9/9/21 at 1100 a.m., indicated the resident was scheduled to receive a shower on Wednesdays and Sundays on day shift. During an interview, on 9/9/21 at 1:24 p.m., the ADON indicated she was unable to find information to show that Resident's C or D had		**changes will be made to ensure that deficient practice does not recur?** Shower tracking form will be utilized by all supervising floor staff (ie: floor nurse/QMA) daily to ensure all showers are performed and documented. **4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur?** **ie: what QA program will be put into place and by what date will they be completed.** Shower tracking forms will be reviewed 5 times weekly by DON/designee for completion. **5. By what date will the systematic changes be completed?** **9/28/2021**	

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	received any additional showers or bed baths. Review of a current facility policy, titled "Personal Hygiene," with a revised date of 6/21 and provided by the DON on 9/9/21 at 3:49 p.m. indicated, "Purpose: To ensure residents receive necessary care and assistance for personal hygiene tasks...Policy:...2. Residents will be offered a shower/full bath at a minimum of 2 times a week. Resident preferences will be honored...." This Federal tag relates to Complaint IN00361477. 3.1-38(a)(3)			
F 0689 SS=J Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure a severely cognitively impaired resident, who was at risk for elopement, remained in the locked dementia unit for 1 of 3 residents reviewed for elopement (Resident B). The immediate jeopardy began on 8/22/21 when the severely cognitively impaired resident eloped from the facility's locked dementia unit and walked through the facility's fenced in area,	F 0689	**Immediate Jeopardy POC** F689/ F609 Called 9/8/2021 Albany Health & Rehabilitation Center 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	09/28/2021

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	through an unlocked gate and followed the fence line behind the facility and circled around to the front of the facility. The Administrator, DON, Nurse Consultant and ADON were notified of the immediate jeopardy at 4:10 p.m. on 9/8/21. The IJ was removed on 9/9/21, but noncompliance remained at the lower scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: Resident B's clinical record was reviewed on 9/8/21 at 10:27 a.m. Diagnoses included, but were not limited to, cellulitis, dementia without behavioral disturbance, essential (primary) hypertension, edema, muscle weakness (generalized), need for assistance with personal care, cognitive communication deficit and anxiety disorder. Her medications included, but were not limited to, escitalopram oxalate (anti-anxiety) 10 milligram (mg) daily, hydrocodone-acetaminophen (pain reliever) 5-325 mg three times daily, hydrochlorothiazide (diuretic) 12.5 mg daily, memantine (cognition enhancer) 5 mg twice daily, donepezil (cognition enhancer) 5 mg daily, meloxicam 7.5 mg daily, Give 1 tablet by mouth at bedtime for pain, orphenadrine citrate extended release (muscle relaxant) 100 mg every 12 hours. Tablet Extended Release 12 Hour 100 MG Give 100 mg by mouth every 12 hours for muscle relaxant. An admission Minimum Data Set (MDS), dated 8/16/21, indicated she was severely cognitively impaired. She required extensive assistance of two staff members for transfers, walking in her room and corridor and locomotion on and off the		**practice.** Resident was safely returned to the secured Memory Care Unit within 15 minutes of exiting the unit. Resident was immediately assessed and found to have no signs of physical injury and showed no signs of mental anguish. 2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents residing on the Memory Care unit could be at risk. Elopement Risk Assessments were updated on all residents and Care Plans with appropriate interventions were updated as needed. Elopement Binders were reviewed and found to be current to include all residents found to be at risk for elopement. 3. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Any resident upon admission or re-admission or re-admission to the facility, will have an elopement risk assessment completed and appropriate care planning will be	

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	unit. She used a walker and a wheelchair. She did not exhibit wandering behaviors. An admission elopement risk assessment, dated 8/13/21, indicated she was an elopement risk. She had a focused care plan initiated, on 8/27/21, that indicated she was an elopement risk and wore a code alert bracelet. Her goal was she would remain safely inside the facility using her care plan interventions. Her interventions were code alert bracelet to be worn on her left leg at all times, monitor for exit seeking behavior, offer activities as appropriate. She had a focused care plan initiated, on 8/30/21, that indicated she was at risk for elopement as evidenced by wandering without purpose. Her goal was she would continue to respond to redirection/diversionary activities during exit seeking episodes. Her interventions included, but were not limited to, she would reside on a secured unit, she wore a security device to alert staff that she was trying to leave the unit/facility, her security device would be checked for function and placement and offer her diversional activities when she attempted to or voiced a desire to leave. The clinical record lacked any indication of the elopement. During an initial tour of the facility, on 9/8/21 at 9:52 a.m., the ADON indicated there had been no elopements in the last couple months in the memory care unit. During an interview with RN 15, on 9/8/21 at 11:20 a.m., she indicated she had heard Resident B had eloped from the building on a Sunday, two		completed. An elopement in-service was conducted for staff on 8/23/21, to include education on elopement risk and maintaining a safe environment by ensure doors are secured to prevent elopement. While the exit door located on the Memory Care Unit seemed to be functioning properly, the door was supplied with a new keypad, power supply and loud horn on 8/31/21 to ensure and extra layer of security. The exit doors are on the TELS Preventative Maintenance schedule and are checked weekly by the Director of Plant Operations to ensure that they are working properly. The Administrator and the Director of Clinical Services were reeducated on the policy and Guidelines for Reporting Unusual Occurrences to the IDOH. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** The Director of Plant Operations will audit and inspect all exit doors on a weekly basis with supporting documentation in the TELS Monitoring system, all concerns and findings will be forwarded by the Director of Plan Operations to the Health Facility Administrator	

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	to three weeks ago. The resident exited the memory care unit. The door alarm had not worked and a new door alarm was installed. Resident B hit the door handle multiple times and shook the door and the door opened for her. Resident B walked outside, which was a fenced in area with three gates. The one gate was unlocked near the 100 hall entrance and thought she got out to the employee parking lot through the unlocked gate. She was found in the front yard or at the front of the building by the DON. They tried as much as possible to keep the residents in the area they were working in and tried to watch the halls also. Sometimes they would entertain the residents at the door if they were exit seeking, like they looked for a squirrel. She felt the resident was now getting acclimated to the facility since she was a newer admission. During an interview, on 9/8/21 at 12:27 p.m., with the Administrator and with DON, ADON, Nurse Consultant present, she indicated Resident B had followed a staff member out of the memory care door. CNA 26 had gone outside to the garage to gather supplies and take out the trash. Resident B got out while the door was unlocked from CNA 26 exiting the door, she wasn't sure what time of day it was but it was early afternoon on 8/22/21. The nurse that was working found the resident outside. The DON indicated she drove by and saw someone outside and called LPN 21 to check. The resident walked out after CNA 26 went to the garage and the resident walked passed the garage and around to the front of the building. The gate was normally locked. The DON indicated LPN 21 was instructed to do a head to toe assessment on the resident when she brought her back into the facility. Corporate had came in the next day to look at the alarm on the door and put a new siren		and the QAA committee for further response and monitoring. The Administrator of her designee will audit all new admissions and all re-admissions to ensure that an Elopement Risk Assessment was completed for 4 weeks and until 100% compliance; and then 5 admissions or readmissions per month for 6 months and until 100% compliance is maintained to ensure Elopement Risk Assessments are completed. Administrator and Director of Clinical Services were reeducated on the Policy and Guidelines for reporting Unusual Occurrences. 5. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** It is important to note that the above corrective measures were completed prior to 9/8/2021 when the Immediate Jeopardy notification was made.	

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	155432	A. BUILDING 00 B. WING	09/09/2021

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	on it. The Administrator indicated they had not reported the elopement to the state agency. During an outdoor tour with RN 15, on 9/8/21 at 1:10 p.m., the door from the memory care was exited to a sidewalk, to the right was a padlocked gate. To the left was a sidewalk the length of the building and chained link fencing ran along with the sidewalk, half way down the sidewalk was a double gate that was chained and padlocked, a sidewalk led from the 200 hall exit door to the double gate. Further down the sidewalk was a locked shed and at the 100 hall exit door was a padlocked gate that led to the employee parking lot with a garage. During a telephone interview with LPN 21, on 9/8/21 at 3:17 p.m., she indicated on 8/22/21, the DON had called the facility and notified her that the resident was in the yard in front of the building. She went outside and asked the resident what she was doing and the resident indicated she did not know how she got there. She took the resident inside and did an assessment on her, the DON came in checked the camera and the resident's husband came to visit and Nurse 21 informed her husband what had happened, she also notified the doctor and completed a behavior sheet. One of the girls had went out that door and took the trash out. The door was supposed to shut and latch and Resident B pushed on it and then walked away from the door then walked back to the door the second time and it opened. Sometimes they do use that door to exit and enter depending on the aide. Resident B would roam the halls. She was sitting in the dining room and had gotten up and walked the hall like usual. The investigation of the incident was reviewed on			

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	9/8/21 at 3:25 p.m. A behavior sheet completed by LPN 21 on 8/22/21 at 4:40 p.m. indicated the resident moderately wandered (without purpose), she had moderate repetitive questions. The precipitating factors were unknown and her environment (uncomfortable). The behavior had happened more than three times. Interventions with improved outcomes were approach in a calm manner, identified self, establish eye contact, called resident by name, explained what they were going to do, used simple sentences and phrases involved in a task, talked with the resident. The comments indicated the resident exited back door and found by LPN 21 and assisted resident back into the facility with no issue. Resident was very cooperative and friendly, and no injuries were noted. A typed statement signed by the DON, dated 8/22/21, indicated, but was not limited to the following, she was driving by the facility and noticed a woman standing in the yard in the front of the building in the grass near the parking lot and was walking towards the building. She called the facility and asked LPN 21 to check. LPN 21 called the DON back and indicated it was Resident B. The Administrator was notified. Review of the surveillance video indicated CNA 26 exited through the west exit door, direct from the locked dementia unit, into the courtyard area. She took out the trash, put the trash into the dumpster, then proceeded into the garage. The resident approached the same door, pushed on the door, when the door opened she exited into the courtyard and followed the sidewalk across the courtyard. The CNA was unaware the resident followed her out the door. The nurse on the hall did not have a view of the door at the time. While the CNA was in the garage the resident left the courtyard area and circled around to the front of			

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	the building. On 9/8/21 at 3:39 p.m., the 22 second video clip was reviewed on the Administrator's cell phone of the resident exiting the facility on 8/22/21. The resident was standing at the door, she pushed the door open and the alarm sounded, the resident stepped through the threshold of the doorway, the door closed behind the resident and the alarm stopped sounding. During an observation, of the pathway the resident took outdoors, with the Maintenance Supervisor, on 9/9/21 at 12:53 p.m., indicated the length from the resident exiting the memory care unit to the front of the building was 915 feet by using a measuring wheel. Some of the pathway was sidewalk and some was rugged terrain with close to ankle high grass lawn. The Maintenance Supervisor indicated it was a surprise they had a mowing crew, the grass was supposed to be mowed and behind the facility were woods they went way back in there but they had a fence line that was about 10 feet into the woods. During an interview with the DON, on 9/9/21 at 1:26 p.m., she indicated she had spoken with the Administrator, the Administrator had indicated the day of the elopement the DON had told her the resident was outdoors for10 minutes and some seconds. DON indicated she knew this because she watched the surveillance camera from inside the building when Resident B exited the unit and the camera that was mounted in the courtyard to the time she had seen her while she was driving by. A current facility policy, titled "ELOPEMENT/MISSING RESIDENT POLICY," provided by the Nurse Consultant, on 9/8/21 at			

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	3:00 p.m., indicated the following: "POLICY: ...4. Should an employee notice a cognitively impaired resident who was found outside the facility and whose whereabouts had been unknown or is attempting to leave the facility, he/she should: a. Attempt to prevent the departure and/or redirect resident back to facility...." The immediate jeopardy that began on August 22, 2021 was removed September 9, 2021 when the facility updated all residents elopement risk assessments and care plans with appropriate interventions, elopement binders were reviewed and updated, all staff received education to ensure the gate was secured and locked when unattended, an audit tool was developed to ensure Elopement Risk Assessments were completed for all admissions and readmissions, the Administrator and DON were re-educated on the policy and guidelines for reporting unusual occurrences, an Audit tool was developed to ensure the gate was locked and functioning properly and the Equipment Lifecycle System (TELS) preventative maintenance log was reviewed to ensure that the exit door and mag locks had been monitored weekly to ensure proper functioning, but the noncompliance remained at no actual harm, but potential for minimal harm that is not immediate jeopardy because education and monitoring was on going. This Federal tag relates to Complaint IN00361477. 3.1-45(a)(2)			