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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175172	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/14/2022
NAME OF PROVIDER OR SUPPLIER		P CODE
Excel Healthcare and Rehab Topeka		
plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
		des adequate supervision to prevent ONFIDENTIALITY** 22686 residents identified at risk for ff knowledge). Based on record supervision to prevent an isk for elopement, and had impaired cluded four residents identified at nout staff knowledge). Based on equate supervision to prevent an isk for elopement, and had impaired let R1 outside into the enclosed out of the line of sight of CNA M. M went back to look for R1, R1 ch inside the facility but were unable the facility. Approximately one hour han 0.5 miles from the facility. CNA upervision and allowed R1 to he courtyard and left the facility in Immediate Jeopardy. diagnoses of dementia (a mental ke decisions, and solve problems); ction or structure); late onset 65); amnesia, (an inability to nearing loss following a cerebral
	IDENTIFICATION NUMBER: 175172 R Ca Dalan to correct this deficiency, please com SUMMARY STATEMENT OF DEFICE (Each deficiency must be preceded by Ensure that a nursing home area is accidents. **NOTE- TERMS IN BRACKETS H The facility reported a census of 10 elopement (when a resident leaves review, observation, and interview, elopement for Resident (R) 1, who cognition. The facility reported a cer risk for elopement (when a resident record review, observation, and int elopement for Resident (R) 1, who cognition. On 07/12/22 at approxim courtyard. R1 proceeded to walk to CNA M then escorted another resid was gone. CNA M then alerted oth to locate the resident. Staff began and five minutes later, CNA N loca M returned R1 to the facility. The fa wander outside of visualization res without staff knowledge or supervis Findings included: - R1's Electronic Medical Record (fd disorder in which a person loses th encephalopathy, (a broad term for Alzheimer's disease, (a progressivy remember events for a period of tir vascular accident, (difficulty with he the brain).	IDENTIFICATION NUMBER: A. Building 175172 B. Wing R STREET ADDRESS, CITY, STATE, ZI Ca STREET ADDRESS, CITY, STATE, ZI Data to correct this deficiency, please contact the nursing home or the state survey SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying informati Ensure that a nursing home area is free from accident hazards and provia accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT C The facility reported a census of 102 residents. The sample included four elopement (when a resident leaves the premises or safe area with out state review, observation, and interview, the facility failed to provide adequate = elopement for Resident (R) 1, who was independent with ambulation, at r cognition. The facility reported a census of 102 residents. The sample included four risk for elopement, (R) 1, who was independent with ambulation, at r cognition. On 07/12/22 at approximately 10:10 AM Certified Nurse Aid M courtyard. R1 proceeded to walk towards the back area of the courtyard, CNA M then escorted another resident back into the building. When CNA was gone. CNA M then alerted other facility staff failed to provide adequates and five minutes later, CNA N located R1 by a food establishment more to the five minutes later, CNA N lo

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: 175172	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/14/2022
NAME OF PROVIDER OR SUPPLIER Excel Healthcare and Rehab Topeka		STREET ADDRESS, CITY, STATE, ZIP CODE 2515 SW Wanamaker Road Topeka, KS 66614	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	D PREFIX TAG SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by		on)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety	The Admission Minimum Data Set (MDS) dated [DATE] recorded R1 had a Brief Interview for Mental Status score of nine, which indicated R1's cognition was moderately impaired. R1 had wandering behavior daily during the assessment period. The MDS recorded R1 as independent with most activities of daily living (ADL's) including transfers, dressing, and toileting, and R1 ambulated without use of assistive devices. The Behaviors Care Area Assessment (CAA) dated 05/05/22 recorded R1 wandered about the facility and		
Residents Affected - Few	wore an alarming bracelet (Wanderguard- bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) to indicate when R1 neared a facility entry and/or exit.		
	An admission Elopement Risk assessment dated [DATE] recorded a score of 14, which placed the resident at high risk for elopement.		
	Follow-up Elopement Risk Assessments dated 06/01/22 recorded R1 was at greater risk for elopement with a score of 26.		
	distract the resident by offering plea	22 documented the resident was at risk asant diversions, attempt to identify any ion if needed, and check placement of	y pattern to target interventions,
	A Social Service Progress Note dated 05/11/22 timed 12:19 PM. documented R1 stated he was leaving the facility, and R1 removed the left ankle alarm bracelet. The note documented staff redirected R1.		
	A Social Service Progress Note dated 07/12/22 at 08:56 AM (94 minutes before the elopement) recorded R was agitated, wanted to leave the facility unaccompanied, and wanted to take the bus to his fiance's house. Social Services X explained to R1 he would need to have an escort due to his cognition and memory issues R1 became agitated, but accepted redirection.		
	R1's clinical record lacked any documentation regarding the circumstances surrounding the elopement, or a descriptive narrative and/or timeline of R1'elopement from the facility.		
	X, Administrative Nurse F, and the	ted 07/12/22 at 11:49 AM (after the elo Consultant GG met with R1 to evaluate irected, and R1's responsible party was	e R1's wellbeing. R1 was agitated
	area for fresh air and left the reside had a broken lock. At 10:30 AM sta sweep to look for R1. Staff drove a AM R1 returned to the facility on his assessed the resident. Consultant	I on 07/12/22 a staff member took R1 c ont alone. It was speculated that the res off noted R1 was missing and performer round the area and looked for R1. The s own and walked in the front door. Co GG gave an order for Ativan (an antian on. The investigation noted the residen irt.	sident exited through a gate that d a room sweep, and outside investigation documented at 11:1 nsultant GG was in the facility and xiety medication) and sent the
	(continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175172	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/14/2022
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Witness Statement from Agency resident outside in the courtyard fo walked the sidewalks and walked to longer visible. The other resident w documented she assisted the fema the courtyard. Agency CNA M chec secure. Agency CNA M went inside checked R1's room and R1 was no sibling and was found near local fa A Witness Statement from Agency was called, Agency LN H searched mile from the facility, walking towar was headed to his family home nea and return to the facility with Agence front door to his assigned room. According to Wunderground.com of variable winds and fair skies. Observation on 07/14/22 At 10:00 / duty caregiver. R1 wore a personal On 07/14/22 at 11:00 AM observati revealed an alarming maglock key Wanderguard alarm system. The c south end of which was obscured f On 07/14/22 at 11:30 AM observati heavily trafficked road with four lan per hour. R1 had to cross a busy in reach the location where he was fo On 07/14/22 at 10:00 AM R1 rement friend in the hospital. R1 then state he referred to as the tracking device fingernail trimmers. R1 stated he ei- wooden fence slats. R1 demonstra a leg to near the top of the door; R1 On 07/14/22 at 11:46 AM Agency L	Certified Nurse Assistant (CNA) M doc r a late smoke break. R1 knocked on th o the west side of the courtyard toward le resident back inside and then went to cked the locks and the door in that corn a to see if anyone saw R1 come inside of present. Agency CNA M was told R1 st-food restaurants. Licensed Nurse (LN) H documented aft for R1 in a private vehicle. Agency LN d the facility. Agency LN H circled back arby. R1 was reluctant at first, but even by LN H. Upon return, R1 exited the vehicle and 10/13/22 at 10:53 AM the temperature AM revealed R1 walked about the facilit alarm bracelet on R1's left ankle. ion of the area where R1 exited the faci rom the entrance door to the courtyard. Th ourtyard itself revealed an approximate rom the entrance door to the courtyard ion of the area where R1 was found reve es of traffic. The posted speed along the theresection with four lanes of traffic mov- uund, approximately 0.7 miles from the the wited the facility by climbing the brick er ted his agility by standing next to a door 1 stated it's easy for a tall guy. LN G stated the only preventative meas ated that the morning of the elopement	umented she took a female ne window to come outside. R1 s the back area, where he was no out of sight. Agency CNA M o look for R1. R1 was no longer in er and everything on that side was and was told no one saw R1. Staff went over the fence and to see a ter a code grey (missing resident) H located R1 approximately one c, and R1 stated to LN H that R1 tually agreed to enter the vehicle nicle and walked through the facility re was 86 degrees Fahrenheit with ty easily, accompanied by a private lility with Administrative Staff A e door was not equipped with a dy 6-foot-high wooden fence, the trans stretch of the road was 35 miles ring north/south and east/west to facility. R1 stated he was going to visit a splayed the personal alarm, which vere easily removed with a pair of necased standards between the r in the dining room and stretched

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175172	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/14/2022
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		Topeka, KS 66614	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 infor		on)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety	On 07/14/22 at 11:48 AM Agency LN H confirmed finding R1 about a mile south of the facility, by a fast food restaurant. R1 was walking back toward the facility when he was found. Agency LN H stated she pulled alongside R1 and R1 said he was not coming back. Agency LN H stated she asked R1 if he would like to get some fresh air in the car and R1 said yes and got in the car.		
Residents Affected - Few		M Social Services Y stated he assisted es YY said R1 was at a stage in his de ow where he should be.	
	On 07/13/22 At 12:15 PM Consultant GG stated R1 was sent to the hospital for evaluation and treatment and was diagnosed with a urinary tract infection. R1 was placed on antibiotic therapy and returned to the facility.		
	On 07/14/22 at 01:00 PM Administrative Nurse F acknowledged staff allowing R1 to be unsupervised in the courtyard did not follow the facility's policies and procedures.		
	On 07/14/22 at 11:00 AM Administrative Staff A acknowledged residents should not be left outside unattended. Administrative Staff A provided documentation of immediate staff education conducted after the incident.		
	information activation, and search	esident/Elopement revised 01/20/20 pr procedures after a resident eloped fron ny measures to prevent the elopement	n the facility. The policy however,
	ambulation, at risk for elopement, a outside of visualization resulting in	ate supervision to prevent an elopemer and had impaired cognition when facilit R1 climbed over the fence in the court icient practice placed R1 in Immediate	y staff allowed R1 to wander yard and left the facility without staf
	The deficient practice was determin corrective actions on 07/12/22 prior	ned past noncompliance when the facil to the survey event:	ity completed the following
	R1 was evaluated at a local Hospital and returned to the facility. R1 was placed on 1:1 supervision when he returned to the facility on .		
	Psychiatric services were scheduled for R1.		
	An updated elopement risk assessment was completed and R1's Care Plan and Kardex were reviewed and revised with elopement interventions.		
	Staff were re-educated on elopement prevention, safety, and supervision of residents at all times when a resident was outside.		
	All residents in the facility were revi	ewed for Elopement Risk Assessment	S.
	(continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175172	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/14/2022
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0689	Facility Staff were in-serviced on Elopement Prevention, Safety, and line-of-sight Supervision of residents when outside.		
Level of Harm - Immediate jeopardy to resident health or safety	The scope and severity remained a	it a J	
Residents Affected - Few	Findings included:		
	 R1's Electronic Medical Record (EMR), under the Diagnosis tab, listed diagnoses of dementia (a mer disorder in which a person loses the ability to think, remember, learn, make decisions, and solve proble encephalopathy, (a broad term for any brain disease that alters brain function or structure); late onset Alzheimer's disease, (a progressive memory decline occurring after age 65); amnesia, (an inability to remember events for a period of time); speech and language deficit and hearing loss following a cereb vascular accident, (difficulty with hearing and/or articulating words following an interruption of blood flot the brain). The Admission Minimum Data Set (MDS) dated [DATE] recorded R1 had a Brief Interview for Mental S score of nine, which indicated R1's cognition was moderately impaired. R1 had wandering behavior da during the assessment period. The MDS recorded R1 as independent with most activities of daily living (ADL's) including transfers, dressing, and toileting, and R1 ambulated without use of assistive devices. 		
	The Behaviors Care Area Assessment (CAA) dated 05/05/22 recorded R1 wandered about the facili wore an alarming bracelet (Wanderguard- bracelet that sets off an alarm when residents wearing on attempt to exit the building without an escort) to indicate when R1 neared a facility entry and/or exit.		when residents wearing one
	An admission Elopement Risk asse at high risk for elopement.	essment dated [DATE] recorded a scor	e of 14, which placed the resident
	Follow-up Elopement Risk Assessments dated 06/01/22 recorded R1 was at greater risk for elopement with a score of 26.		
	distract the resident by offering plea	22 documented the resident was at risk asant diversions, attempt to identify an ion if needed, and check placement of	y pattern to target interventions,
		ted 05/11/22 timed 12:19 PM. docume kle alarm bracelet. The note document	
	was agitated, wanted to leave the fa	ted 07/12/22 at 08:56 AM (94 minutes acility unaccompanied, and wanted to ne would need to have an escort due to redirection.	take the bus to his fiance's house.
	R1's clinical record lacked any doct descriptive narrative and/or timeline	umentation regarding the circumstance e of R1'elopement from the facility.	es surrounding the elopement, or a
	(continued on next page)		

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AND PLAN OF CORRECTION		A. Building	
	175172	B. Wing	07/14/2022
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
Excel Healthcare and Rehab Tope	ka	2515 SW Wanamaker Road	
		Topeka, KS 66614	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0689 Level of Harm - Immediate jeopardy to resident health or	A Social Service Progress Note dated 07/12/22 at 11:49 AM (after the elopement) recorded Social Services X, Administrative Nurse F, and the Consultant GG met with R1 to evaluate R1's wellbeing. R1 was agitated and confused. R1 was calmed, redirected, and R1's responsible party was contacted and verbalized understanding of the situation.		
safety	The facility's Investigation recorded	l on 07/12/22 o stoff momber took P1 (sutaida ta tha South natia amaking
Residents Affected - Few	 The facility's Investigation recorded on 07/12/22 a staff member took R1 outside to the South patio smothand a process of the resident alone. It was speculated that the resident exited through a gate that a broken lock. At 10:30 AM staff noted R1 was missing and performed a room sweep, and outside sweep to look for R1. Staff drove around the area and looked for R1. The investigation documented at AM R1 returned to the facility on his own and walked in the front door. Consultant GG was in the facility assessed the resident. Consultant GG gave an order for Ativan (an antianxiety medication) and sent th resident to the hospital for evaluation. The investigation noted the resident was dressed in overalls, a long-sleeved shirt, and an undershirt. A Witness Statement from Agency Certified Nurse Assistant (CNA) M documented she took a female resident outside in the courtyard for a late smoke break. R1 knocked on the window to come outside. Find the sidewalks and walked to the west side of the courtyard towards the back area, where he was longer visible. The other resident was done smoking shortly after R1 went out of sight. Agency CNA M documented she assisted the female resident back inside and then went to look for R1. R1 was no long the courtyard. Agency CNA M checked the locks and the door in that corner and everything on that sid secure. Agency CNA M went inside to see if anyone saw R1 come inside and was told no one saw R1. checked R1's room and R1 was not present. Agency CNA M was told R1 went over the fence and to se sibling and was found near local fast-food restaurants. 		sident exited through a gate that d a room sweep, and outside investigation documented at 11:15 nsultant GG was in the facility and uxiety medication) and sent the
			ne window to come outside. R1 s the back area, where he was no c out of sight. Agency CNA M to look for R1. R1 was no longer in the and everything on that side was and was told no one saw R1. Staff
	was called, Agency LN H searched mile from the facility, walking towar was headed to his family home near	Licensed Nurse (LN) H documented a l for R1 in a private vehicle. Agency LN d the facility. Agency LN H circled bacl arby. R1 was reluctant at first, but even cy LN H. Upon return, R1 exited the vel	H located R1 approximately one , and R1 stated to LN H that R1 tually agreed to enter the vehicle
	According to Wunderground.com on 07/12/22 at 10:53 AM the temperature was 86 degrees Fahrenheit with variable winds and fair skies.		
	Observation on 07/14/22 At 10:00 AM revealed R1 walked about the facility easily, accompanied by a private duty caregiver. R1 wore a personal alarm bracelet on R1's left ankle.		
	revealed an alarming maglock key Wanderguard alarm system. The c	on of the area where R1 exited the fac coded door to the facility courtyard. Th ourtyard itself revealed an approximate rom the entrance door to the courtyard	e door was not equipped with a ely 6-foot-high wooden fence, the
	heavily trafficked road with four lan per hour. R1 had to cross a busy ir	on of the area where R1 was found re- es of traffic. The posted speed along the tersection with four lanes of traffic mov- und, approximately 0.7 miles from the	nat stretch of the road was 35 mile ring north/south and east/west to
	(continued on next page)		
		und, approximately 0.7 miles from the	тасшту.

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For information on the nursing home's	plan to correct this deficiency, please con	•	agency.
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICI (Each deficiency must be preceded by f		CIENCIES full regulatory or LSC identifying informati	on)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 07/14/22 at 10:00 AM R1 remembered exiting the facility on 07/13/22. R1 stated he was going to visit as friend in the hospital. R1 then stated he was going to visit his sister. R1 displayed the personal alarm, which he referred to as the tracking device on his ankle, and stated the alarms were easily removed with a pair of fingernail trimmers. R1 stated he exited the facility by climbing the brick encased standards between the wooden fence slats. R1 demonstrated his agility by standing next to a door in the dining room and stretches a leg to near the top of the door; R1 stated it's easy for a tall guy. On 07/14/22 at 11:46 AM Agency LN G stated the only preventative measures known for R1 wandering was the Wanderguard. Agency LN G stated that the morning of the elopement, R1 verbalized that he wanted to go home so all staff watched R1 at intervals.		
	restaurant. R1 was walking back to	N H confirmed finding R1 about a mile ward the facility when he was found. A not coming back. Agency LN H stated s id yes and got in the car.	gency LN H stated she pulled
		M Social Services Y stated he assisted ses YY said R1 was at a stage in his de now where he should be.	
		nt GG stated R1 was sent to the hospi infection. R1 was placed on antibiotic t	
	On 07/14/22 at 01:00 PM Administr courtyard did not follow the facility's	rative Nurse F acknowledged staff allow s policies and procedures.	wing R1 to be unsupervised in the
		rative Staff A acknowledged residents a provided documentation of immediate a	
	information activation, and search	esident/Elopement revised 01/20/20 pr procedures after a resident eloped from ny measures to prevent the elopement	the facility. The policy however,
	ambulation, at risk for elopement, a outside of visualization resulting in	ate supervision to prevent an elopemer and had impaired cognition when facility R1 climbed over the fence in the courty icient practice placed R1 in Immediate	y staff allowed R1 to wander yard and left the facility without sta
	The deficient practice was determin corrective actions on 07/12/22 prior	ned past noncompliance when the facil r to the survey event:	ity completed the following
	R1 was evaluated at a local Hospit returned to the facility on .	al and returned to the facility. R1 was p	placed on 1:1 supervision when he
	(continued on next page)		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	ion)
F 0689	Psychiatric services were schedule	d for R1.	
Level of Harm - Immediate jeopardy to resident health or safety	An updated elopement risk assessment was completed and R1's Care Plan and Kardex were reviewed and revised with elopement interventions.		
Residents Affected - Few	Staff were re-educated on elopemeresident was outside.	ent prevention, safety, and supervision	of residents at all times when a
	All residents in the facility were revi	iewed for Elopement Risk Assessment	S.
	Facility Staff were in-serviced on Elopement Prevention, Safety, and line-of-sight Supervision of residents when outside.		
	The scope and severity remained a	at a J	