STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345449	A. BUILDING _____ B. WING _____	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/KING	115 WHITE ROAD KING, NC 27021

(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) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint investigation was conducted on 9/15/21 - 9/16/21. 2 of the 22 complaint allegations were substantiated and resulted in deficient practice. Event ID #NXYK11	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to place a resident's call light within reach to allow for the resident to request staff assistance if needed for 1 of 3 residents (Resident #3) reviewed for accommodation of needs. Findings included: Resident #3 was admitted to the facility on 6/27/15 with diagnoses that included, in part, chronic obstructive pulmonary disease and chronic pain syndrome. The 5 day Minimum Data Set assessment dated 8/30/21 revealed Resident #3 had moderately impaired cognition. She required supervision with bed mobility and limited assistance with transfers. An activities of daily living (ADL) care plan updated 1/1/21 revealed, "keep call light within	F 558	This Plan of Correction submitted in compliance with applicable law and regulation. To demonstrate continuing compliance with applicable law, the center has taken or will take the actions set forth in the following allegation of compliance. The following Plan of Correction constitutes the center□s allegation of compliance. All alleged deficiencies have been or completed by the dates indicated. How corrective action accomplished for those residents found affected by the deficient practice. Resident # 3 had her call light cord hanging on the wall behind her bed for two consecutive days (9/14/21 and 9/15/21) and out of reach. Resident #3 call light was immediately placed within reach for resident #3 on	10/10/21

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

Electronically Signed | 10/08/2021

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F 558	Continued From page 1 arm's length and teach how to use call light to request assistance." On 9/14/21 at 10:03 AM Resident #3 was observed in her bed. The call light cord was hung on the wall behind Resident #3's bed and was out of reach of the resident. During an interview with Resident #3 on 9/14/21 at 10:04 AM, she said she didn't know there was a call light available for her to use to summon staff for assistance. An interview was completed with Nurse Aide (NA) #4 on 9/14/21 at 3:48 PM, during which she stated Resident #3 made her needs known to staff. She explained staff routinely checked on the resident and if Resident #3 needed something, she let the staff know when they checked on her. An observation on 9/15/21 at 10:16 AM revealed Resident #3 was in bed asleep. The call light cord was hung on the wall behind Resident #3's bed and was out of reach of the resident. Resident #3 was observed in bed on 9/15/21 at 1:28 PM. She said she was resting. The call light cord was hung on the wall behind Resident #3's bed and was out of reach of the resident. NA #5 was interviewed on 9/15/21 at 2:21 PM. She shared when she finished working with a resident she made sure the call light was within reach and either handed the call light to a resident or placed it near a resident so it could be reached to call for assistance. An observation of Resident #3's room was completed with the Director of Nursing (DON) on 9/15/21 at 1:31 PM. The call light cord was hung	F 558	9/15/21 How the facility will identify other residents having the potential affected by the same deficient practice. 100% call bell audit conducted by the DON and Restorative aide on 9/15/2021 to assure all call bells were in reach and properly placed at that time. No other call bells identified to be out of reach upon observation. C.N.A and nursing staff were immediately in-service on call bell placement within reach for residents at all times. Address what measures put into place or systemic changes made to ensure that the deficient practice will not recur: Education began on 10/04/2021 by SDC (Staff Development Coordinator) for call bells within reach to assure that all nursing staff received education by 10/07/2021. An all-staff meeting done on 10/04/21 by Administrator to educate all staff on proper call bell placement and call bells within reach. All new hired nurse management and nurses and C.N.A will be educated on proper call bell placement and call bells within reach during orientation by SDC. Administrator will in-services weekend Managers on Duty will complete room rounds on at least one to two rooms to assure all call bells properly placed and	

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F 558	Continued From page 2 on the wall behind Resident #3's bed and was out of reach of the resident. During an interview with the DON on 9/15/21 at 1:32 PM she expressed NAs were responsible to place call lights within reach of residents after they provided ADL care in the morning. The DON added that regardless if a resident used the call light, it was supposed to be placed within reach of a resident at all times. An interview was completed with the Administrator on 9/15/21 at 3:45 PM during which he verified staff were to place the call light within reach of a resident after they worked with the resident. He added Resident #3 completed "a lot of her own care" and thought the resident hung her call light on the wall but stated if the call light had been there for two days then staff should have placed it back within reach of the resident.	F 558	within reach. Any call bells found not within reach will corrected immediately, placed within reach, and reported to DON/ADON for monitoring, tracking, trending, re-education, and corrective action as needed. SDC, ADON, RN supervisor, or unit coordinator, will conduct an audit of call light placement and within reach of resident weekly X 4 weeks, biweekly X 2 weeks, and monthly X 1. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X1 for further problem resolution if needed. Date of compliance is OCT 10, 2021. Director of Nursing is responsible for ensuring continued compliance.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	F 656		10/10/21

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F 656	Continued From page 3 describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to implement care plan interventions for 1 of 2 residents (Resident #2) reviewed for implementation of the comprehensive care plan. The findings included:	F 656	The Plan of Correction was submitted in compliance with applicable laws and regulation. To demonstrate continued compliance with applicable law, the center has taken or will take the actions set forth, in the following direction of compliance. The Plan of Correction constitutes the	

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F 656	Continued From page 4 Resident #2 was admitted to the facility on 5/21/2020 with diagnoses that included, legally blind, hemiplegia, anxiety, bilateral below the knee amputations, Bipolar and paranoid schizophrenia. A review of the quarterly Minimum Data Set (MDS) dated 8/5/2021 revealed Resident #2 was cognitively intact with behaviors for psychosis, verbal behaviors and behaviors directed towards others for 4 to 6 days of the lookback period. A review of the comprehensive care plan dated 5/7/2021 revealed a focused problem area identified as verbally aggressive behaviors with interventions that included talk in a calm voice when behavior was disruptive, remove from public area when behavior was disruptive, reinforce unacceptability of verbal abuse, praise for demonstrating desired behavior, monitor and document target behaviors, elicit family input for best approach to resident, do not argue with resident, discuss options for appropriate channeling of anger, assist in selection of appropriate coping mechanisms, provide diversional activities. An interview was conducted with Nursing Assistant #1 on 9/14/2021 and she revealed that Resident #2 had frequent episodes of yelling at staff and residents. She stated when she was the NA working with the resident she would just ignore the yelling. She stated she learned Resident #2 and how to interact with her. She denied having access to care plan interventions and stated that was for a nurse. She revealed the NA's had access to a Kardex but behavior interventions were not included for the named	F 656	center□s direction of compliance. All alleged deficiencies have been or will be addressed by the dates indicated. How corrective action is accomplished for those residents found affected by the deficient practice. The facility failed to implement care plan interventions for resident #2 behaviors, and interventions for C.N.A and nursing staff to follow. MDS nurses/SW updated Resident #2 care plan accordingly to reflect current behaviors with interventions, documented them on Kardex immediately on 9/15/21 How the facility will identify other potential residents affected by the same deficient practice. MDS nurses/SW to review all residents in the facility care plans and Kardex accurately, to ensure interventions for behaviors are accessible for all nursing and staff to follow by 10/10/21. Address what measures put into place or systemic changes made to ensure that the deficient practice will not recur: Administrator/DON/Designee □ Will conduct in-service with MDS and IDT on care plan with the interventions on Kardex, for all staff to follow with the current interventions for behavioral residents by 10/10/21	

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F 656	Continued From page 5 Resident. She denied receiving report from staff for other interventions. An interview was conducted with the Staff Development coordinator (SDC) on 9/15/2021 at 9:47 AM and she revealed that NA's received training during orientation and included to review the Kardex for all interventions and care planned care items. She demonstrated the location of the Kardex's for the B hall. The Kardex for Resident #2 was reviewed compared to the Care plan dated 5/7/2021. She revealed based on the way she trains staff at the facility, the behavior interventions from the care plan for Resident #2 should be included on the Kardex and were not included. An interview was conducted with NA #2 on 9/15/2021 at 11:04 AM and she revealed she was an agency NA working with Resident #2 on the shift. She stated she knew what care to provide and interventions to use based on the Kardex. She stated Resident #2's Kardex did not include anything for behavior interventions. An interview was conducted with the Director of Nursing on 9/16/2021 and she revealed that it was her expectation that care plan interventions be included on the NA Kardex if it pertains to care being provided by the NA. She added that it was her expectation that Resident #2 have behavior interventions reported to the NA's prior to each shift or on the Kardex.	F 656	Indicate how the facility plans to monitor its performance to make sure that solutions sustained: MDS/IDT will monitor Care plan updates with Admission/ Annual/Quarterly/Significant changes. They will also update to reflect behavior changes to Kardex, for all staff to follow with current intervention for behavioral residents. MDS/IDT will monitor utilizing MDS assessment schedule upon completion of assessment to identified behaviors. Then behaviors are care planned and documented on Kardex. Results of these audits will be reviewed at Quarterly Quality Assurance meeting x 1 for further problems resolution if needed. Date of compliance is OCT 10, 2021. Administrator is responsible for ensuring continued compliance.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must	F 657		10/10/21

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F 657	Continued From page 6 be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to update the care plan for a resident identified to be a wandering resident in 1 of 1 resident (Resident #8) reviewed for accidents and safety. The findings included: Resident #8 was admitted to the facility on 4/14/2021 with diagnoses that included dementia, cognitive communication deficit and insomnia.	F 657	This Plan of Correction submitted in compliance with applicable law and regulation. To demonstrate continuing compliance with applicable law, the center has taken or will take the actions set forth in the following allegation of compliance. The following Plan of Correction constitutes the center□s allegation of compliance. All alleged deficiencies have been or completed by the dates indicated. How corrective action accomplished for	

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F 657	Continued From page 7 A review of the elopement risk tool indicated completion on admission, dated 4/14/2021 and did not document wander or elopement risk. Review of a quarterly Minimum Data Set (MDS) dated 6/14/2021 indicated that Resident #8 was moderately cognitively impaired for daily decision making and required extensive assist of one staff member for activities of daily living (ADL). The MDS further indicated that Resident #8 wandered 1 day during the lookback period. A review of the care plan dated 6/14/2021 did not include a focused area for Risk of wandering or elopement. A review of Resident #8's progress notes included a note documented on 6/20/2021 at 10:50 PM that read Resident wandering into neighboring rooms. Resident arguing with other residents. A review of Resident #8's progress notes included a note documented on 6/30/2021 at 5:26 PM that read Resident going into several other residents' rooms. Very verbally aggressive towards other residents and staff. A review of Resident #8's progress notes included a note documented on 8/11/2021 at 4:32 AM that read observed resident crawling into the hallway from her room. Resident was assisted back to bed. She attempted to get out of bed several times. Resident was agitated and attempted to get up from wheelchair numerous times, stating she needed to go back to bed. A review of Resident #8's progress notes included a note documented on 9/9/2021 at 7:37 AM written by Nurse #1. The progress note read	F 657	those residents found affected by the deficient practice. F657- Care Plan Timing and Revision: Facility failed to update the care plan for a resident identified to be wandering. Resident #8 care plan was updated immediately for wandering and wander guard device placed on her wrist. Resident#8 placed in the elopement book and wandering behavior care plan completed and placed on Kardex on 9/16/2021. Staff educated on elopement and wander guard placed on resident wrist on 9/16/21. How the facility will identify other residents having the potential affected by the same deficient practice. Nursing staff completed 100% elopement audit to identify any other potential resident affected by the same deficient practice 9/16/2021. MDS will complete 100% audit tool to includes checking the resident□s care plan, Kardex to validate they match each other and contain all pertinent information needed to inform staff on any resident with wandering behavioral and at risk for elopement by 10/10/2021. Address what measures put into place or systemic changes made to ensure that the deficient practice will not recur: Nursing and IDT will ensure that the	

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F 657	Continued From page 8 Resident alert with increased confusion. She had to be redirected several times. She was noted going in and out of other residents' rooms during the night. At 4 AM Resident was found outside, in front of the facility building, saying that she was waiting to be picked up. A head-to-toe assessment was completed with no injuries noted. Resident was put on 15-minute monitoring for 24 hours. Nurse Practioner (NP) was notified. On 9/14/2021, a partial tour was made of the unit where Resident #8 resided. The Resident was observed sitting in her wheelchair, inside of another resident's room (room 115), unsupervised. She remained in the room for 5 minutes and then propelled herself into the hall. A wander guard device was not observed on Resident #8 or her wheelchair. An interview was conducted with Nursing Assistant #1 on 9/14/2021 and she revealed that Resident #8 often wanders into other residents' rooms. An interview was conducted on 9/15/2021 at 11:10 AM and she revealed that on 9/9/2021 resident #8 became increasingly confused during the night shift and required redirection. She stated she began to have 15-minute supervision of the resident. At 3:58 AM, she noticed the Resident was missing from the hall and began to look for her. She stated she asked all staff to begin to help look for the Resident. At 4 AM she discovered Resident #8 outside of the facility, near the gazebo area, wearing a t shirt and pants, no shoes and in her wheelchair. She stated the temperature was warm but not hot and it was not raining. Nurse #1 stated she reported the incident to the Director of Nursing (DON) and the NP. She	F 657	baseline care plan is completed timely after admission by reviewing the resident in morning clinical meeting. At this time the care plan will be reviewed and updated as necessary for any wandering behavior and risk for elopement. The RN supervisor will address the residents that are due for upcoming assessments with the ARD for completing the Elopement assessment daily on nursing assignment sheet. Administrator/DON/Regional Nurse Consultant will conduct in-service with MDS nurse/ADON/Nursing supervisor/SDC and IDT on Care Plan Timing and Revision and updating Kardex to validate they match each other and contain all pertinent information needed to inform staff on any resident with wandering behavioral and at risk for elopement by 10/10/2021. MDS will monitor MDS will complete audit tool to includes checking the resident□s care plan, Kardex to validate they match each other and contain all pertinent information needed to inform staff on any resident with wandering behavioral and at risk for elopement weekly x 4 weeks, bi-weekly x 2 weeks and monthly x 1 DON/ADON/Nursing supervisor will monitor weekly x 4 weeks, bi-weekly x 2 weeks and monthly x 1 using the Quality Assurance Monitoring tool to ensure elopement assessment are completed on all residents with ARD (Assessment□s	

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F 657	Continued From page 9 added she reported this to the NP because she had observed Resident #8 had insomnia and did not have a sleep medication aid. An interview was conducted with the DON on 9/16/2021 and she revealed that she received a phone call from Nurse #1 on the morning of 9/9/2021. She stated Nurse #1 reported that Resident #8 had been placed with a Nursing Assistant for observation and safety. She stated Nurse #1 had reported Resident #8 had been outside but the report of an NA being placed with her caused confusion and she had thought the resident was not alone. She stated that she had read the progress note written on 9/9/2021 by Nurse #1. She stated the note indicated she had been discovered outside of the facility by staff. She added that she had misunderstood and did not report the incident to the Administrator or other members of the Interdisciplinary team. She revealed it was the facility policy to conduct elopement risk screenings on admission and quarterly for all Residents. She stated Resident #8 was due for a screening in July 2021 and every 90 days. She reported based on her review of the nursing progress notes and Resident #8 would have assessed as a wandering resident. She denied an update being conducted to Resident #8's plan of care to indicate Resident #8 was identified as wandering.	F 657	reference date). Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X1 for further problem resolution if needed. Date of compliance is OCT 10, 2021. Administrator/Director of Nursing is responsible for ensuring continued compliance.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §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	F 689		10/10/21

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F 689	Continued From page 10 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to provide supervision to prevent a cognitively impaired resident (Resident #8) from exiting the facility unsupervised and from wandering into 1 of 1 resident's (Resident #2) room and yelling. The findings included: 1) Resident #8 was admitted to the facility on 4/14/2021 with diagnoses that included dementia, cognitive communication deficit and insomnia. A review of the elopement risk tool indicated completion on admission, dated 4/14/2021 and did not document wander or elopement risk. Review of a quarterly Minimum Data Set (MDS) dated 6/14/2021 indicated that Resident #8 was moderately cognitively impaired for daily decision making and required extensive assist of one staff member for activities of daily living (ADL). The MDS further indicated that Resident #8 wandered 1 day during the lookback period. A review of the care plan dated 6/14/2021 did not include a focused area for Risk of wandering or elopement. A review of Resident #8's progress notes included a note documented on 6/20/2021 at 10:50 PM that read Resident wandering into neighboring rooms. Resident arguing with other residents.	F 689	The Plan of Correction was submitted in compliance with applicable laws and regulation. To demonstrate continued compliance with applicable law, the center has taken or will take the actions set forth, in the following direction of compliance. The Plan of Correction constitutes the center□s direction of compliance. All alleged deficiencies have been or will be addressed by the dates indicated. How corrective action is accomplished for those residents found affected by the deficient practice. Facility failed to provide supervision to prevent a cognitively impaired resident (Resident#8) from exiting the facility unsupervised and from wandering into other resident□s (Resident #2) room and yelling. Resident #8□s care plan was updated immediately for wandering and the need for a wander guard device placed on her wrist. Resident # 8 placed in the elopement book and wandering behavior documented on Kardex. Staff were educated on elopement and wander guard policy on 9/16/21 by SDC. Nursing implemented the use of Stop signs at resident #2 door to prevent resident# 8 from wandering into her room. How the facility will identify other potential	

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	345449	A. BUILDING _____ B. WING _____	C 09/16/2021

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F 689	Continued From page 11 A review of Resident #8's progress notes included a note documented on 6/30/2021 at 5:26 PM that read Resident going into several other residents' rooms. Very verbally aggressive towards other residents and staff. A review of Resident #8's progress notes included a note documented on 8/11/2021 at 4:32 AM that read observed resident crawling into the hallway from her room. Resident was assisted back to bed. She attempted to get out of bed several times. Resident was agitated and attempted to get up from wheelchair numerous times, stating she needed to go back to bed. A review of Resident #8's progress notes included a note documented on 9/9/2021 at 7:37 AM written by Nurse #1. The progress note read Resident alert with increased confusion. She had to be redirected several times. She was noted going in and out of other residents' rooms during the night. At 4 AM Resident was found outside, in front of the facility building, saying that she was waiting to be picked up. A head-to-toe assessment was completed with no injuries noted. Resident was put on 15-minute monitoring for 24 hours. Nurse Practioner (NP) was notified. On 9/14/2021 1:08 PM, a partial tour was made of the unit where Resident #8 resided. The Resident was observed sitting in her wheelchair, inside of another resident's room (room 115), unsupervised. She remained in the room for 5 minutes, until 1:12 PM and then propelled herself into the hall. A wander guard device was not observed on Resident #8 or her wheelchair. An interview was conducted on 9/15/2021 at 11:10 AM and she revealed that on 9/9/2021	F 689	residents affected by the same deficient practice. Nursing staff completed a 100% elopement risk assessment on 9/16/21 to identify any other potential residents affected by the same deficient practice. Address what measures put into place or systemic changes made to ensure that the deficient practice will not recur: DON will educate Nursing staff on utilizing the Quality Assurance Monitoring tool (Case Mix Charting) to ensure elopement assessments are completed with residents MDS assessments. If a resident is identified to have wandering behavior, it must be reflected in their care plan and documented on resident Kardex, in a timely manner by 10/10/2021. DON will educate RN supervisors to monitor all admission for completion of elopement assessment during morning meeting and update the communication board in charting room/nursing assessment sheet of any upcoming assessment due. Education on completed by 10/10/21 DON/ADON/Nursing supervisor will use the (Case Mix Charting sheet) to conduct an audit for Elopement Assessments completed on all residents that are in the assessment period according to the assessments ARD. (Weekly X 4 weeks, biweekly X 2 weeks, and monthly X 1)	

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F 689	Continued From page 12 resident #8 became increasingly confused during the night shift and required redirection. She stated she began to have 15-minute supervision of the resident. At 3:58 AM, she noticed the Resident was missing from the hall and began to look for her. She stated she asked all staff to begin to help look for the Resident. At 4 AM she discovered Resident #8 outside of the facility, near the gazebo area, wearing a t shirt and pants, no shoes and in her wheelchair. She stated the temperature was warm but not hot and it was not raining. Nurse #1 stated she reported the incident to the Director of Nursing (DON) and the NP. She added she reported this to the NP because she had observed Resident #8 had insomnia and did not have a sleep medication aid. An interview was conducted with the Administrator on 9/15/2021 at 11:20 AM and he revealed he was not aware of an elopement by Resident #8. He read the progress note dated 9/9/2021 and stated he would begin an investigation immediately. He stated the facility utilizes a wander guard alarm system for at risk of wander or elopement residents. An observation was conducted on 9/15/2021 at 2:15 PM and Resident #8 was observed to not be wearing a wander guard alarm bracelet. An interview was conducted with the DON on 9/16/2021 and she revealed that she received a phone call from Nurse #1 on the morning of 9/9/2021. She stated Nurse #1 reported that Resident #8 had been placed with a Nursing Assistant for observation and safety. She stated Nurse #1 had reported Resident #8 had been outside but the report of an NA being placed with	F 689	Indicate how the facility plans to monitor its performance to make sure that solutions sustained: Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X1 for further problem resolution if needed. Date of compliance is OCT 10, 2021. Director of Nursing is responsible for ensuring continued compliance.	

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her caused confusion and she had thought the resident was not alone. She stated that she had read the progress note written on 9/9/2021 by Nurse #1. She stated the note indicated she had been discovered outside of the facility by staff. She added that she had misunderstood and did not report the incident to the Administrator or other members of the Interdisciplinary team. She revealed it was the facility policy to conduct elopement risk screenings on admission and quarterly for all Residents. She stated Resident #8 was due for a screening in July 2021 and every 90 days. She reported based on her review of the nursing progress notes and Resident #8 would have assessed as a wandering resident.

2) Resident #2 was admitted to the facility on 5/21/2020 with diagnoses that included, legally blind, hemiplegia, anxiety, bilateral below the knee amputations.

A review of the quarterly MDS dated 8/5/2021 revealed Resident #2 was cognitively intact for decision making.
On 9/14/2021, a partial tour was made of the unit where Resident #8 resided. The Resident was observed sitting in her wheelchair, inside of another resident's room (Resident #2), unsupervised. She remained in the room for 5 minutes and then propelled herself into the hall. A wander guard device was not observed on Resident #8 or her wheelchair.

An interview was conducted with Nursing Assistant (NA) #1 on 9/14/2021 at 12:41 PM and she revealed that she worked with Resident #8 and Resident #2 during her assignments in August and September 2021. She added that Resident #8 frequently wanders into other

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Residents rooms and when she wanders into Resident #2's room, Resident #2 will yell and ask her to leave. She stated that Resident #8 will also yell at Resident #2. She added that she was not aware of an intervention used to stop Resident #8 from entering rooms other than redirecting her attention.

An interview was conducted with Resident #2 on 9/14/2021 at 1:42 PM and she revealed that Resident #8 wanders into her room and sometimes yells at her. She stated she does not like this because she cannot see what the Resident is doing because of her blindness. She stated she had reported this to nursing staff, Nursing assistant staff and Administration. She stated she will be told how to conduct herself and to not argue or be verbally aggressive with another resident, but they do nothing, to her knowledge, to try to keep Resident #8 out of her room. She added she does not want Resident #8 to touch her urinary catheter or intravenous fluids and cause an issue.

An interview was conducted with the Administrator on 9/14/2021 at 1:57 PM and he revealed Resident #2 and Resident #8 had a long history of screaming and yelling. He stated the issue between the two residents was because Resident #8 was jealous over Resident #2 because she will converse with Resident #8's husband when sitting outside. He revealed that staff had to provide education to Resident #2 on various occasions for the desired behavior when dealing with other staff and when yelling at Residents. He denied attempts being made to keep Resident #8 from wandering into Resident #2's room.