STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345008	A. BUILDING _____ B. WING _____	C 12/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL AT MYERS PARK, LLC	300 PROVIDENCE ROAD CHARLOTTE, NC 28207

(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
E 006 SS=D	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency	E 006		12/15/23

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

Electronically Signed | 12/20/2023

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.

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E 006	Continued From page 1 Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with Resident #1, the Physician (MD), Nurse Practitioners (NP), staff and record review, the facility failed to notify law enforcement per their emergency operations plan when Resident #1 left the facility but failed to return to the facility as planned. Resident #1 remained away from the facility for over 24 hours after his expected return, without communication to the facility. This failure occurred for 1 of 3 sampled residents reviewed for elopement (Resident #1). The findings included:	E 006	On 11/26/2023, Resident #1 returned to the facility with no acute distress. The resident was placed on 1:1 to monitor for any adverse effects from being out of the facility, and none were noted. The Social Services Director completed a new BIMs score to assess the resident's cognitive level. The Nurse Practitioner assessed the resident within 24 hours of his return with new orders for psychotherapy reassessment, speech therapy evaluation to determine the possibility of cognitive decline and follow up with neurology for routine care. The Director of Nursing	

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E 006	Continued From page 2 The facility policy, Rapid Response guidelines of the All-Hazards Emergency Operations Plan, Missing Resident, reviewed 3/13/23, documented in part, "If the missing resident is not found following an expedient search, call 911." Resident #1 was admitted to the facility on 6/29/23 with diagnoses that included alcoholic dementia classified mild, and depression. The medical record for Resident #1 documented the Resident was his own responsible party (RP) with family as the emergency contact. A quarterly Minimum Data Set assessment dated 10/9/23, assessed Resident #1 with adequate hearing/vision, clear speech, understood and able to understand, no corrective lenses or use of hearing aids, intact cognition, no change in mood and no wandering behavior. He required supervision of one person for activities of daily living (ADL), ambulated without mobility devices, no impairment with range of motion, occasional incontinence, no falls, and an active discharge plan to return to the community. A Release of Responsibility for Leave of Absence (LOA) document for Resident #1, recorded the Resident's name but the "Sign Out" and "Sign In" sections were blank. The document recorded "Authorization must be signed by the resident and/or legal representative." A nurse progress note, dated 11/24/23, by Nurse #1 recorded the Nurse was notified by Nurse Aide (NA) #1 on 11/24/23 at 2:00 PM that Resident #1 could not be located. The progress note recorded the Nurse last saw Resident #1 during the lunch meal at 12:30 PM to 12:45 PM on 11/24/23. The	E 006	made the resident an identification card that included the contact information for the facility. On 11/27/2023, the Interdisciplinary Team (IDT), met with the resident to educate him on the facility procedures for signing out for leave of absences (LOA) from the facility. All residents who leave the facility independently have the potential to be affected by this alleged deficient practice. On 11/27/2023, the Administrator completed a questionnaire of all residents who leave the facility independently of ensure comprehension of the (LOA) guidelines that include, signing both in and out, notifying the nursing staff of their intention to leave, and having their identification cards accessible. On 11/27/2023, the Administrator audited the LOA books kept at each nursing station to ensure that the books were being used appropriately and that all residents who leave the facility are signing in and out. All books were being used appropriately and all residents who had signed out for LOA had signed back into the facility. On 12/01/2023, the Administrator, DON, and ADON began educating staff concerning: a) The procedures for both the staff and the residents for LOAs from the facility. b) The Emergency Preparedness plan includes calling emergency services when a resident does not return from an LOA.	

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E 006	Continued From page 3 progress note documented that Nurse #1 and NA #1 checked the Resident's room, staff searched throughout the facility and drove a two-mile radius with no resolve. Resident #1 was not located, and the Director of Nursing (DON) was contacted to advise of the Resident's absence. NA #1 was interviewed on 11/28/23 at 12:47 PM and stated that she was the 7:00 AM - 3:00 PM NA for Resident #1 on Friday, 11/24/23. She stated that Resident #1 never made comments to her about plans to leave the facility, and she last saw him and spoke to him on Friday, 11/24/23 at 1:05 PM. NA #1 stated that Nurse #1 called code silver to notify staff of an elopement, staff searched for him, but could not locate him. NA #1 stated that when she returned to work on Saturday, 11/25/23, Resident #1 was still not in the facility, but she was told that staff got in touch with him and that he said he was coming back so she did not think 911 needed to be contacted since he told staff that he was coming back. Nurse #1 was interviewed by phone on 11/28/23 at 4:18 PM. Nurse #1 stated that she worked on Friday, 11/24/23 for the first time in the facility on the 7:00 AM - 3:00 PM shift. Nurse #1 further stated that around 2:00 PM, NA #1 told her that she could not locate Resident #1 and that his cell phone and charger were also missing. Nurse #1 stated she called the DON who advised her to search in the facility and to drive a few blocks around the facility to look for him. Nurse #1 stated staff searched but did not find him. Nurse #1 stated that when she returned to the facility after searching for Resident #1, she notified the DON that she did not find the Resident and asked if staff should call 911 to report him missing. The Nurse stated that the DON advised her not to call	E 006	c) The facility's Elopement policy and where to locate the Elopement Risk Binders. d) Calling emergency services when a resident refuses to sign out. e) Reporting to the Administrator and/or DON when a resident does not follow the LOA procedures. f) Licensed nurses are to complete a full body assessment for the reasons including but are not limited to: when residents return from an extended LOA, LOA in which the circumstances could possible indicate a risk event, such as not returning from LOA at the stated time and when there has been a change in the resident's condition. On 12/01/2023, the Medical Records Department completed an update of the Elopement Risk Binders to include anyone who is at risk of eloping. This binder includes the picture, demographics, and responsible party contact information, if applicable. On 12/05/2023, the Administrator held an Ad Hoc meeting to review the facility policies for Emergency Preparedness Plan. During this review the IDT ensured that this plan identified strategies to address emergency events identified by the resident's risk assessments, strategies for natural disasters, power failures, and other emergencies that would require an emergency plan. The Administrator will review the LOA binders at each nursing desk three times	

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E 006	Continued From page 4 911 because the SSD spoke to the Resident, and the Resident said he was coming back. Nurse #1 stated that when she left the facility at about 3:45 PM, Resident #1 had not returned so she called the DON before leaving to let her know that he was not back, and asked again if staff should alert authorities, but she was told no. The Social Services Director (SSD) recorded a progress note dated 11/24/23 and documented that the SSD was notified that Resident #1 left the facility without signing out of the facility. The progress note documented that the SSD contacted Resident #1 by phone and spoke to the Resident to ask why he didn't sign out of the facility. Resident #1 stated that he forgot but that he would return to the facility later that day. The SSD stated in an interview on 11/28/23 at 12:31 PM that he received a call from the DON on Friday, 11/24/23 letting him know that Resident #1 left the facility and did not sign out. The SSD stated he called Resident #1 at 2:37 PM and the Resident said he forgot to sign out but that he would be back later that day. The SSD stated he spoke to the DON again on Friday 11/24/23 to see if Resident #1 had returned and was told he had not come back, so the SSD said he called Resident #1 again, on Friday, 11/24/23 at 3:03 PM and 4:09 PM. The SSD said Resident #1 did not answer, so he left a message, but Resident #1 did not call back. The SSD said he did not call 911 or notify any other agencies to report Resident #1 missing because he had no reason to think that Resident #1 would not come back. The DON recorded a progress note on 11/25/23 at 10:29 AM which indicated "Resident #1 with	E 006	a week for four weeks, twice a week for four weeks, and weekly for four weeks to ensure compliance with the LOA policy. The DON, ADON, and Unit Managers will complete a questionnaire with staff weekly for 12 weeks to ensure comprehension of the LOA and Elopement policy. The Director of Social Services will complete a questionnaire with residents who sign out independently to ensure compliance and comprehension of the LOA policy. Residents who do not follow this procedure a course of action will then be determined which may include re-education to the facility procedures, referrals to therapy and/or the medical provider for evaluation of cognition and safety needs. The results of these audits will be discussed weekly in the clinical risk meeting for 12 weeks and monthly in QAPI for three months. The QAPI committee will make recommendations appropriate to the results of the audit outcomes.	

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E 006	Continued From page 5	E 006		

BIMS (Brief Interview for Mental Status) of 13" had not returned to the facility, after contact and stating that he would be back. The progress note indicated that "texts and calls" placed to Resident #1 were to no avail, and staff were awaiting a call back.

A nurse progress note dated 11/26/23 by the Nurse Supervisor recorded Resident #1 returned to the facility on 11/26/23 at 7:15 PM. The Resident informed the Nurse that he was "dropped off" by non-emergency hospital transportation. The Nurse Supervisor documented that Resident #1 returned without signs of substance abuse, he had a calm demeanor, no agitation, no inappropriate behavior, or distress noted and that the DON was notified of his return.

An interview with the Business Office Manager occurred on 11/28/23 at 3:21 PM. The Business Office Manager stated that he received a phone call from the DON on Saturday 11/25/23, but he was not sure of the time. The DON said Resident #1 went on LOA on Friday, 11/24/23 but did not sign out, the SSD spoke to him on 11/24/23 and Resident #1 said he was coming back, but that he had not returned. The Business Office Manager stated that he had a good rapport with Resident #1, the DON provided the Resident's phone number, so the Business Office Manager called him, left a message, but never received a return call. The Business Office Manager stated that he did not call 911 when he was made aware that Resident #1 said he was coming back to the facility but had not returned or when Resident #1 did not respond to his phone call.

An interview with both the Administrator and DON

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E 006	Continued From page 6	E 006		

occurred on 11/28/23 at 12:09 PM. The DON stated that NA #1 called her on Friday 11/24/23 around 2:23 PM to notify her that she last saw Resident #1 after lunch and when she did another round at about 2:00 PM, she did not see him. NA #1 stated she searched his room and the unit but did not see him. NA #1 said that it appeared he took his cell phone and charger and whatever he had on his nightstand, because his nightstand was empty. The DON stated Nurse #1 was his assigned Nurse that day and that it was her first time working in the facility. The DON stated Nurse #1 called her and reported that Resident #1 had eloped. The DON stated that the incident was not an elopement because Resident #1 was alert/oriented with intact cognition. The DON stated that the SSD contacted Resident #1 on 11/24/23 at 2:35 PM and Resident #1 said he forgot to sign out but would return later that day. The DON stated that when Resident #1 did not come back to the facility on Friday, 11/24/23, staff called him throughout the day on Friday, 11/24/23 and Saturday, 11/25/23, but he did not answer, and he did not return the calls. The DON stated Resident #1 showed up at the facility on Sunday, 11/26/23 around 7:15 PM uninjured. The DON stated that staff did not contact any other agencies while Resident #1 was on LOA to report him missing because he said he was coming back. The Administrator reviewed the facility's Missing Resident policy during the interview and stated that the facility did not consider him missing because of his cognition, independence with ADL and that he communicated a plan to return to the facility. The Administrator further stated that when Resident #1 did not return, the facility considered that was his choice not to return.

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F 000	Continued From page 7	F 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 11/28/23 to conduct a complaint investigation survey and exited on 11/29/23. Additional information was obtained on 11/30/23 and 12/01/23. Therefore, the exit date was changed to 12/01/23. Event ID# MSG311. The following intake was investigated, NC00210237. One of one complaint allegation resulted in deficiency.	F 000		
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 §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, interviews with Resident #1, family, the Physician (MD), Nurse Practitioners (NP), staff and record review, the facility failed to identify the risk for elopement for Resident #1 when Resident #1 left the facility, and the facility was unaware of his departure or his whereabouts. This failure occurred for 1 of 3 sampled residents reviewed for elopement (Resident #1). The findings included: The facility policy, Elopements and Wandering Residents, Missing Resident, implemented 11/1/20, documented in part, "This facility ensures	F 689	On 11/26/2023, Resident #1 returned to the facility with no acute distress. The resident was placed on 1:1 to monitor for any adverse effects from being out of the facility, and none were noted. The Social Services Director completed a new BIMs score to assess the resident's cognitive level. The Nurse Practitioner assessed the resident within 24 hours of his return with new orders for psychotherapy reassessment, speech therapy evaluation to determine the possibility of cognitive decline and follow up with neurology for routine care. The Director of Nursing made the resident an identification card	12/15/23

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F 689	Continued From page 8 that residents who are at risk for elopement receive adequate supervision to prevent accidents ...Elopement occurs when a resident leaves the premises without authorization." The facility policy, Leave of Absence (LOA), dated 2020, recorded in part, "All residents leaving the premises, excluding transfers/discharges, must be signed out." Resident #1 admitted to the facility on 6/29/23 from the hospital with diagnoses that included alcoholic dementia classified mild, depression. The medical record for Resident #1 documented the Resident was his own responsible party (RP) with family as the emergency contact. A 6/29/23 Wandering Assessment indicated Resident #1 was at risk, due to an elopement attempt at a prior facility, date unknown. A Physician (MD) order was obtained, a wander guard (an alarming device) was placed, and Resident #1 was admitted to a room on the facility's secured unit. An admission Minimum Data Set (MDS) assessment dated 7/6/23 assessed Resident #1 with adequate hearing/vision, clear speech, understood, able to be understand, no corrective lenses/hearing aids, intact cognition, no mood, no wandering behavior, required supervision, of one person with activities of daily living (ADL), no impairment with range of motion (ROM), no mobility devices used for ambulation, occasional incontinence, and no falls since admission. A quarterly MDS assessment dated 10/9/23 assessed Resident #1 with adequate	F 689	that included the contact information for the facility. On 11/27/2023, the Interdisciplinary Team (IDT), met with the resident to educate him on the facility procedures for signing out for leave of absences (LOA) from the facility. All residents who leave the facility independently have the potential to be affected by this alleged deficient practice. On 11/27/2023, the Administrator completed a questionnaire of all residents who leave the facility independently of ensure comprehension of the (LOA) guidelines that include, signing both in and out, notifying the nursing staff of their intention to leave, and having their identification cards accessible. On 11/27/2023, the Administrator audited the LOA books kept at each nursing station to ensure that the books were being used appropriately and that all residents who leave the facility are signing in and out. All books were being used appropriately and all residents who had signed out for LOA had signed back into the facility. On 12/01/2023, the Administrator, DON, and ADON began educating staff concerning: a) The procedures for both the staff and the residents for LOAs from the facility. b) The Emergency Preparedness plan includes calling emergency services when a resident does not return from an LOA. c) The facility's Elopement policy.	

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F 689	Continued From page 9	F 689		

hearing/vision, clear speech, understood, able to understand, no corrective lenses/hearing aids, intact cognition, no change in mood and no wandering behavior. He required supervision of one person for ADL, ambulated without mobility devices, no impairment with ROM, occasional incontinence, no falls, and an active discharge plan to return to the community.

Resident #1 was assessed by the MD on 10/10/23 as alert, cooperative with no change in cognition. The MD indicated his medications were reviewed and the plan was to continue the current plan of care and medications.

A Transfer/Mobility Evaluation dated 10/11/23 assessed Resident #1 as independent with ambulation, steady gait, no difficulty standing, full weight bearing, alert and oriented, able to follow directions, and able to remain seated on the bedside without support.

A Wandering Assessment dated 10/11/23 documented Resident #1 was without wandering risk as evidenced that he followed instructions, was ambulatory, communicated verbally, and had no reported episodes of wandering or expressions to leave the facility in the past 6 months. The wander guard was removed, and Resident #1 was moved to a room off the secured unit.

In a psychiatric follow up progress note dated 10/19/23, the Psychiatric Mental Health Nurse Practitioner (PMHNP) recorded Resident #1 was referred for a psychiatric assessment and medication management. At the time of the assessment, Resident #1 was identified as calm, cooperative, alert/oriented, no apparent distress,

d) Calling emergency services when a resident refuses to sign out.
e) Reporting to the Administrator and/or DON when a resident does not follow the LOA procedures.
f) Licensed nurses are to complete a full body assessment for the reasons including but are not limited to: when residents return from an extended LOA, LOA in which the circumstances could possible indicate a risk event, such as not returning from LOA at the stated time and when there has been a change in the resident's condition.

On 12/01/2023, the Medical Records Department completed an update of the Elopement Risk Binders to include anyone who is at risk of eloping. This binder includes the picture, demographics, and responsible party contact information, if applicable.

The Administrator will review the LOA binders at each nursing desk three times a week for four weeks, twice a week for four weeks, and weekly for four weeks to ensure compliance with the LOA policy. The DON, ADON, and Unit Managers will complete a questionnaire with staff weekly for 12 weeks to ensure comprehension of the LOA and Elopement policy.

The Director of Social Services will complete a questionnaire with residents who sign out independently to ensure compliance and comprehension of the LOA policy. Residents who do not follow this procedure a course of action will then

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THE CITADEL AT MYERS PARK, LLC	300 PROVIDENCE ROAD CHARLOTTE, NC 28207

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F 689	Continued From page 10 mood/behaviors stable and at baseline with no changes to mental status, substance abuse in remission, and no recommendations. An 11/17/23 comprehensive monthly follow up progress note by the Nurse Practitioner (NP) assessed Resident #1 as pleasant, alert/oriented, stable, sober, no recent substance abuse, and no changes in mood, behavior, or cognition. A Release of Responsibility for LOA document for Resident #1, recorded the Resident's name but the "Sign Out" and "Sign In" sections were blank. The document recorded "Authorization must be signed by the resident and/or legal representative." A nurse progress note, dated 11/24/23, by Nurse #1 recorded the Nurse was notified by Nurse Aide (NA) #1 on 11/24/23 at 2:00 PM that Resident #1 could not be located. The progress note recorded the Nurse last saw Resident #1 during the lunch meal at 12:30 PM to 12:45 PM on 11/24/23. The progress note documented that Nurse #1 and NA #1 checked the Resident's room, staff searched throughout the facility and drove a two-mile radius with no resolve. Resident #1 was not located, and the Director of Nursing (DON) was contacted to advise of the Resident's absence. The Social Services Director (SSD) recorded a progress note dated 11/24/23 and documented that the SSD was notified that Resident #1 left the facility without signing out of the facility. The progress note documented that the SSD contacted Resident #1 and spoke to the Resident to ask why he didn't sign out of the facility. Resident #1 stated that he forgot but that he would return to the facility later that day.	F 689	be determined which may include re-education to the facility procedures, referrals to therapy and/or the medical provider for evaluation of cognition and safety needs. The results of these audits will be discussed weekly in the clinical risk meeting for 12 weeks and monthly in QAPI for three months. The QAPI committee will make recommendations appropriate to the results of the audit outcomes.	

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The DON recorded a progress note on 11/25/23 at 10:29 AM which indicated "Resident #1 with BIMS (Brief Interview for Mental Status) of 13" had not returned to the facility, after contact and stating that he would be back. The progress note indicated that "texts and calls" placed to Resident #1 were to no avail, and staff were awaiting a call back.

A nurse progress note dated 11/26/23 by the Nurse Supervisor recorded Resident #1 returned to the facility on 11/26/23 at 7:15 PM. The Resident informed the Nurse that he was "dropped off" by non-emergency hospital transportation. The Nurse Supervisor documented that Resident #1 returned without signs of substance abuse, he had a calm demeanor, no agitation, no inappropriate behavior, or distress noted and that the DON was notified of his return.

A NP routine follow up progress note dated 11/27/23 recorded nursing reported Resident #1 went on LOA on Friday, 11/24/23 and returned Sunday 11/26/23. The progress note documented that Resident #1 was his own RP and had significant improvement in cognitive function since admission in June 2023. The progress note recorded that Resident #1 reported to NP he went on LOA to clear his mind and stayed overnight at the hospital for the weekend without seeking admission. The NP recorded that per nursing, the Resident returned without incident and his cognition was "13/15 and at baseline." The NP recorded that Resident #1 was contacted by staff on 11/24/23 and reported he forgot to sign out but that he planned to return. The NP noted that a comprehensive physical evaluation was

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performed on 11/27/23 with no signs of self-harm, impairment or signs of psychoactive substances noted. The NP documented that Resident #1 was assessed safe to sign out of the facility unsupervised with no immediate or current concerns for his safety.

In a psychiatric follow up progress note dated 11/28/23, the PMHNP recorded Resident #1 was referred for psychiatric assessment, medication management and provider follow-up. The progress note recorded that nursing staff reported to the PMHNP on 11/28/23 that Resident #1 left the facility for a few days but did not sign out. The PMHNP documented that at the time of the assessment, Resident #1 was evasive, restricted, and noncontributory when questioned about his activities during his absence. He reported to the PMHNP that he forgot to sign out before leaving, he was lonely and spent time thinking about his son.

Resident #1 was observed and interviewed on 11/28/23 at 11:30 AM. He was noted ambulating in the hallway independently, wearing a long-sleeved shirt, pants, shoes, hat, and jacket. Resident #1 complimented his nursing care and stated he felt safe and comfortable, and all the staff treated him well at the facility. When asked if he recently left the facility he stated "Yes, to be honest with you I just needed to get away, I'm struggling inside with some goals I have not reached yet and that frustrates me." When asked several times how he exited facility, he stated repeatedly, that after lunch, "I just walked out." When asked if he told anyone he was leaving, Resident #1 stated, "No, I just left, I should have told my Nurse, I just needed to get out to clear my head, I was coming back. I went to the hospital

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and just sat there. I did not get admitted or get treated, I just sat there to clear my head." Resident #1 stated that he had not spoken to or seen his family in several weeks and that he missed his family. He stated that he came back to the facility with non-emergency transportation. Resident #1 stated that the SSD called him while he was away from the facility and that he told the SSD that he was coming back. Resident #1 also stated that while he was away, the battery on his cell phone "died," and "something" happened to his cell phone charger so he could not call back to the facility to notify that he would be returning later. Resident #1 denied substance abuse, or incident/injury while on LOA, he stated that he kept identification with his name and the facility's address and that he knew who to call if he needed help. Resident #1 further stated that he knew his way around the city, stating "I am an adult, I can take care of myself," and requested to end the interview with no further questions about his activities while on LOA.

A phone interview with a family member for Resident #1 occurred on 11/30/23 at 2:01 PM. The family member stated that the family was called and notified that Resident #1 left facility on the afternoon of Friday, 11/24/23 and then received another call on Sunday, 11/26/23 advising that Resident #1 had returned to the facility. The family member stated that the family last visited Resident #1 in the facility Thanksgiving Day, 11/23/23 around 9:00 PM and he was doing well. The family stated that during the visit, Resident #1 did not express a desire to leave the facility but was tearful about not being able to see his son and expressed he wanted to see his son.

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NA #1 was interviewed on 11/28/23 at 12:47 PM and stated that she was the 7A - 3P NA for Resident #1 on Friday, 11/24/23. She stated that Resident #1 never made comments to her about plans to leave the facility, he often smoked unsupervised on the back porch, which was not enclosed, and she last saw him and spoke to him on Friday, 11/24/23 at 1:05 PM. NA #1 described that Resident #1 was wearing jeans, shoes, a blue hat, and black jacket. NA #1 stated that during her rounds on 11/24/23 at about 1:45 PM or 2:00 PM, Resident #1 was not in his room and that she did not see him on the unit. NA #1 stated that she noticed some of his personal items were gone (cell phone and charger) from his room, so she reported to Nurse #1 that she did not see Resident #1 on the unit, and she did not see his cell phone or charger. NA #1 stated that Nurse #1 called code silver to notify staff of an elopement, staff searched for him, but could not locate him. NA #1 stated that when she returned to work on Saturday, 11/25/23, Resident #1 was still not in the facility, but she was told that staff got in touch with him and that he said he was coming back.

Nurse #1 was interviewed by phone on 11/28/23 at 4:18 PM. Nurse #1 stated that she worked on Friday, 11/24/23 for the first time in the facility on the 7A - 3 P shift and that she was unfamiliar with Resident #1. She stated that on 11/24/23, she provided morning/afternoon medications to Resident #1, she did not recall the times, but stated that he did not express a desire to leave the facility. Nurse #1 stated she saw Resident #1 again around 12:30 PM seated in the dining room eating his lunch until about 12:45 PM. Nurse #1 described him wearing a hat, long-sleeved shirt, pants, shoes, and a jacket. Nurse #1 further stated that around 2:00 PM, NA #1 told her that

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she could not locate Resident #1 and that his cell phone and charger were also missing. Nurse #1 stated she called the DON who advised her to search in the facility and to drive a few blocks around the facility to look for him. Nurse #1 stated staff searched but did not find him. Nurse #1 stated that when she returned to the facility after searching for Resident #1, she notified the DON that she did not find the Resident.

A review of the November 2023 Medication Administration Record (MAR) during the interview with Nurse #1 on 11/28/23 she confirmed that she administered the following medications to Resident #1 during the morning/afternoon medication pass on 11/24/23:

" Amlodipine Besylate 10 milligrams (mg) once daily (9:00 AM) for hypertension
" Aricept 5 mg once daily (9:00 AM) for dementia
" Chlorthalidone 25 mg once daily (9:00 AM) for hypertension
" Losartan Potassium 50 mg once daily (9:00 AM) for hypertension
" Potassium Chloride, Extended Release, 10 milliequivalents (MEQ) once daily (9:00 AM) for hypokalemia
" Sertraline 50 mg once daily (9:00 AM), for depression
" Thiamine (vitamin B12) Hydrochloride 250 mg once daily (9:00 AM) for vitamin B12 deficiency
" Carbamazepine 200 mg twice daily (9:00 AM and 5:00 PM) for neurocognitive disorder
" Carvedilol 12.5 mg twice daily (9:00 AM and 9:00 PM) for hypertension
" Buspirone Hydrochloride 5 mg three times daily (9:00 AM, 2:00 PM and 9:00 PM) for anxiety

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The SSD stated in an interview on 11/28/23 at 12:31 PM that he received a call from the DON on Friday, 11/24/23 letting him know that Resident #1 left the facility and did not sign out. The SSD stated he called Resident #1 at 2:37 PM and the Resident said he forgot to sign out but that he would be back later that day. The SSD stated he spoke to the DON again on Friday 11/24/23 to see if Resident #1 had returned and was told he had not come back, so the SSD said he called Resident #1 again, on Friday, 11/24/23 at 3:03 PM and 4:09 PM. The SSD said Resident #1 did not answer, so he left a message, but Resident #1 did not call back. The SSD said when he came to work on Monday, 11/27/23, he was notified that Resident #1 came back to the facility on Sunday, 11/26/23, so the SSD re-evaluated the Resident's cognition on 11/27/23 which resulted in a score of 13/15, which was his baseline. He stated that he was actively working with Resident #1 to move closer to his family per the Resident's request.

An interview with the Business Office Manager occurred on 11/28/23 at 3:21 PM. The Business Office stated that he saw Resident #1 in the facility on Wednesday, 11/23/23, but that he was off on Thursday/Friday, 11/24/23 and 11/25/23. The Business Office Manager stated that he received a phone call from the DON on Saturday 11/25/23, but he was not sure of the time. The DON said Resident #1 went on LOA on Friday, 11/24/23 but did not sign out, the SSD spoke to him on 11/24/23 and Resident #1 said he was coming back, but that he had not returned. The Business Office Manager stated that he had a good rapport with Resident #1, the DON provided the Resident's phone number, so the Business Office Manager called him, left a message, but

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never received a return call.

Nurse #3 was interviewed on 11/29/23 at 12:25 PM and stated that he arrived at the facility for the 7AM - 3PM shift on Saturday, 11/25/23 and was notified in shift report that Resident #1 eloped. Nurse #3 stated that he was told that staff spoke to the Resident on Friday, 11/24/23, the Resident expressed a plan to return, but that he had not returned. Nurse #3 described Resident #1 as alert/oriented, cooperative, went outside to smoke independently, and returned to his room. The Nurse said, Resident #1 left the facility before with visitors and knew his way around the city but to the Nurse's knowledge Resident #1 had never left the facility alone and had never communicated a desire to leave.

A phone interview with Nurse #2 occurred on 11/29/23 at 1:06 PM. Nurse #2 stated that she was the Nurse assigned to Resident #1 on the 3PM - 11PM shift on Sunday 11/26/23. Nurse #2 stated she was notified by Nurse #3 in shift report that Resident #1 left the facility on 11/24/23 but did not sign out. Nurse #3 stated that Resident #1 returned to the facility at about 7:15 PM on Sunday, 11/26/23. The Nurse stated she was not familiar with Resident #1 as this was her first time working in the facility in "many years." The Nurse described that the Resident did not appear in any distress, he was alert/oriented, well-groomed, dressed in pants, shirt, jacket, and shoes. The Nurse could not recall if he was wearing a hat. The Nurse stated that she "saw nothing of concern" for the Resident when he returned. Nurse #2 stated that the Nurse Supervisor gave her instructions to administer medications to Resident #1 as ordered, so she administered Resident #1's evening medications that were due

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after 7:15 PM.

A review of the November 2023 MAR during the phone interview with Nurse #2 on 11/29/23 she confirmed that she administered the following medications to Resident #1 during the evening medication pass on 11/26/23:
" Carvedilol 12.5 mg twice daily (9:00 AM and 9:00 PM)
" Buspirone Hydrochloride 5 mg three times daily (9:00 AM, 2:00 PM and 9:00 PM)

A phone interview with the Nurse Supervisor on 11/29/23 at 12:02 PM revealed she was the Nurse Supervisor in the facility on Saturday, 11/25/23 and Sunday 11/26/23. The Nurse Supervisor stated she was made aware that Resident #1 left the facility on Friday, 11/24/23 and that he was not in the facility when she worked on Saturday, 11/25/23. She stated he returned to the facility on Sunday, 11/26/23 around 7:15 PM. She stated that she was the Nurse Supervisor, not the assigned Nurse for Resident #1. She stated she completed a full body assessment and a safety assessment on Resident #1 on Sunday, 11/26/23 when he returned to ensure he was safe to return to the facility. She stated the DON and MD were notified of his return, a MD order was obtained to resume Resident #1's medications, so she advised the Nurse to administer Resident #1's evening medications per MD order that were due after his return to the facility.

A review of the November 2023 MAR during the phone interview with the Nurse Supervisor on 11/29/23 she confirmed that Resident #1 did not receive the following medications while he was away from the facility:

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Friday, 11/24/23:
" Carbamazepine 200 mg twice daily (5:00 PM)
" Carvedilol 12.5 mg twice daily (9:00 PM)
" Buspirone Hydrochloride 5 mg three times daily (9:00 PM)
Saturday, 11/25/23:
" Amlodipine Besylate 10 mg once daily (9:00 AM)
" Aricept 5 mg once daily (9:00 AM)
" Chlorthalidone 25 mg once daily (9:00 AM)
" Losartan Potassium 50 mg once daily (9:00 AM)
" Potassium Chloride, Extended Release, 10 MEQ once daily (9:00 AM)
" Sertraline 50 mg once daily (9:00 AM)
" Thiamine Hydrochloride 250 mg once daily (9:00 AM)
" Carbamazepine 200 mg twice daily (9:00 AM and 5:00 PM)
" Carvedilol 12.5 mg twice daily (9:00 AM and 9:00 PM)
" Buspirone Hydrochloride 5 mg three times daily (9:00 AM, 2:00 PM and 9:00 PM)
Sunday, 11/26/23:
" Amlodipine Besylate 10 mg once daily (9:00 AM)
" Aricept 5 mg once daily (9:00 AM)
" Chlorthalidone 25 mg once daily (9:00 AM)
" Losartan Potassium 50 mg once daily (9:00 AM)
" Potassium Chloride, Extended Release, 10 MEQ once daily (9:00 AM)
" Sertraline 50 mg once daily (9:00 AM)
" Thiamine Hydrochloride 250 mg once daily (9:00 AM)
" Carbamazepine 200 mg twice daily (9:00 AM and 5:00 PM)
" Carvedilol 12.5 mg twice daily (9:00 AM)
" Buspirone Hydrochloride 5 mg three times

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F 689	Continued From page 20 daily (9:00 AM, 2:00 PM) An interview with both the Administrator and DON occurred on 11/28/23 at 12:09 PM. The DON stated that NA #1 called her on Friday 11/24/23 around 2:23 PM to notify her that she last saw Resident #1 after lunch and when she did another round at about 2:00 PM, she did not see him. NA #1 stated she searched his room and the unit but did not see him. NA #1 said that it appeared he took his cell phone and charger and whatever he had on his nightstand, because his nightstand was empty. The DON stated Nurse #1 was his assigned Nurse that day and that it was her first time working in the facility. The DON stated Nurse #1 called her and reported that Resident #1 had eloped. The DON stated that the incident was not an elopement because Resident #1 was alert/oriented with intact cognition. The DON stated that the SSD contacted Resident #1 on 11/24/23 at 2:35 PM and Resident #1 said he forgot to sign out but would return later that day. The DON stated that when Resident #1 did not come back to the facility on Friday, 11/24/23, staff called him throughout the day on Friday, 11/24/23 and Saturday, 11/25/23, but he did not answer, and he did not return the calls. The DON stated Resident #1 showed up at the facility on Sunday, 11/26/23 around 7:15 PM uninjured. The Administrator described Resident #1 as alert/oriented, and that Resident #1 was assessed by the MD/NP as safe to leave the facility unsupervised, but that he needed to follow the LOA policy. The Administrator stated that when Resident #1 returned to the facility, he was re-educated to follow the facility's LOA policy and expressed understanding. The Administrator reviewed the facility's elopement policy during the interview and stated that the facility did not	F 689		

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consider that Resident #1 eloped because of his cognition, independence with ADL and that he communicated a plan to return to the facility. The Administrator further stated that when Resident #1 did not return, the facility considered that was his choice not to return. The Administrator stated that she contacted the hospital and checked the electronic hospital system for triage/admissions and Resident #1 was not in triage or admitted to the hospital on 11/24/23 - 11/26/23.

The NP stated in an interview on 11/28/23 at 1:20 PM that she was notified by the SSD and DON when she arrived at the facility on Friday, 11/24/23 that Resident #1 left the facility, and that she was notified when he returned on Sunday, 11/26/23. The NP stated she assessed Resident #1 on Monday, 11/27/23 and told him what the nurses reported and asked him what happened. The NP said she asked Resident #1 why he did not sign out before leaving the facility on 11/24/23 and he said he forgot, he became tearful as he talked about his son stating that he missed his son, so he left the facility to clear his mind. He stated that while he was gone the battery in his cell phone "died," and he said he lost his phone charger. The NP said his cognition had already been re-evaluated, so she correlated with that assessment and asked him the basics for a mini mental health assessment. The NP stated that his cognition had improved since his admission assessment in June 2023, and that during the assessment he stated that he realized it was important to sign out and to let his Nurse know that he was leaving. The NP stated leaving without signing out was not his character and described Resident #1 as very compliant and respectful. The NP stated that when she assessed Resident #1 on 11/27/23 he was at

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baseline, there was nothing acute or different, he was sad about his son, more open than normal but otherwise he was himself. The NP stated that the diagnosis of depression was not new for him, he smoked independently usually on the back porch, which was not enclosed, came right back, and that he had never expressed a desire to leave the facility. The NP stated he was still safe to leave the facility unsupervised. The NP stated in a follow up interview on 12/1/23 at 9:22 AM that Resident #1 would still have therapeutic levels of the medications in his system and would not be depleted because of missing 1 or 2 doses. The NP stated that the missed doses of medications would not present a significant risk to Resident #1 because he was stable on the medications and had received the medications for a while.

An interview with the PMHNP occurred on 11/28/23 at 1:52 PM and revealed that she was notified on 11/28/23 when she arrived at the facility, that Resident #1 left the facility without signing out and that she was asked to follow up with him. The PMHNP stated she assessed Resident #1 on 11/28/23, he confirmed that he left the facility for a LOA and returned. The PMHNP said Resident #1 was not forthcoming in answering her questions, giving vague answers, or saying, "I don't know." He said, "I just left, I went here and there just thinking about my son." The PMHNP said Resident #1 knew what city he was in but that he said he did not tell anyone in the facility that he was leaving. The PMHNP said she advised Resident #1 not to leave the building without staff knowledge. The PMHNP said "It seems to be a trust factor here and I can't properly help him if I don't know what's really going on with him." The PMHNP said she was not sure if his responses were because of his recall

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F 689	Continued From page 23 or a lack of trust, and would defer to his MD. A phone interview with the Physician (MD) occurred on 11/29/23 at 11:09 AM. The MD stated that he was made aware that Resident #1 left the facility Friday, 11/24/23 and returned on Sunday, 11/27/23. The MD described Resident #1 as alert/oriented and had the "free will to leave the facility." The MD stated staff re-educated Resident #1 on 11/26/23 that a LOA required authorization by signing out/in and that if he went to the hospital the facility staff needed to be made aware since he resided in a nursing facility. The MD stated when he assessed Resident #1 on 10/10/23, he was alert/oriented and safe to leave the facility unsupervised and reassessed by the NP on 11/28/23 to be at baseline with no evidence of injury/incident after he returned. The MD stated that staff did contact him while he was on LOA and Resident #1 expressed, he planned to return. A follow up phone interview with the MD on 12/1/23 at 2:40 PM he stated that he reviewed the medications that Resident #1 missed while he was on LOA from the facility and did not see any missed medications that would have been detrimental to Resident #1. The MD stated he would expect the Nurse to resume the medications that were due when Resident #1 returned to the facility rather than going back to give medications missed because some medications given at 9:00 PM and then again at 9:00 AM could be too much in the system at one time. The MD stated there was no evidence that Resident #1 was unsafe while he was on LOA from the facility.	F 689		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)	F 867		12/15/23

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F 867	Continued From page 24 §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.	F 867		

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F 867	Continued From page 25 §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.	F 867		

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F 867	Continued From page 26 §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification and complaint	F 867	12/01 /2023, the Director of clinical Services educated the Administrator, the Director of Nursing, and the Assistant Director of Nursing on the appropriate function of the QAPI committee to include identifying issues and correction of repeat	

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F 867	Continued From page 27 investigation survey completed on 3/16/23, and the complaint investigation survey completed on 10/25/23. This failure occurred for one repeat deficiency cited for accident hazards, supervision and devices that was subsequently recited on the current complaint investigation survey of 12/01/23. The continued failure of the facility during three federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA Program. The findings included: This tag is cross referenced to: F689: Based on observations, interviews with Resident #1, family, the Physician (MD), Nurse Practitioners (NP), staff and record review, the facility failed to identify the risk for elopement for Resident #1 when Resident #1 left the facility, and the facility was unaware of his departure or his whereabouts. This failure occurred for 1 of 3 sampled residents reviewed for elopement (Resident #1). F689: Based on observations, record review, staff, and nurse practitioner interviews the facility failed to assess a resident's ability to safely operate the motorized wheelchair in the community, failed to educate the resident about safely operating the motorized wheelchair in the community, and failed to attempt safeguards for the resident with a diagnosis of dementia, traumatic brain injury and poor decision-making skills. On the morning of 10/17/23, a Resident left the facility in his motorized wheelchair and was struck by a garbage truck traveling 35 miles per hour (mph) when attempting to cross a four-lane highway with no marked crossing. The Resident	F 867	deficiencies, use of rounding tools, daily review of documentation, and observations during leadership rounds. On 12/05/2023, the Quality Assurance Committee held an Ad Hoc meeting to review the purpose and function of the Quality Assurance Performance Improvement (QAPI) committee as well as reviewed the ongoing compliance related issues regarding F689 Tad received during the 12/01/2023 compliant survey. The Administrator educated the QAPI committee members consisting of the Medical Director, Administrator, Director of Nursing, assisted Director of Nursing/Staff Development Coordinator, Unit Managers, Minimum Data Set Nurse, Dietary Manager, Activities Director, Environmental Services Manager, Director of Social Services, and the Director of Rehabilitation, on potential risk review and of the audit findings for compliance and/or revisions when necessary. The Director of Clinical Services will provide weekly oversight for 12 weeks and will validate the facility's progress, review corrective actions and dates of completion. The administrator will be responsible for ensuring QAPI committee concerns are addressed through further training or other interventions. The QAPI committee will continue to meet monthly to identify issues related to quality assessment and assurance activities as needed and will develop and implement	

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F 867	Continued From page 28 was hospitalized with multiple bilateral fractures of the ribs both displaced and non-displaced, sternal fracture, multiple facial fractures, and spinal fractures, required intubation, and admitted into intensive care unit (ICU) where he remained hospitalized during the survey. In addition, on 8/28/23 a Resident used an unlabeled bottle of a chemical solution he found in a common area to clean the seat of his wheelchair and accidentally sprayed his right pant leg. The Resident reported burning and pain of his right buttocks and the back his right leg at a level of 10 on a pain scale of 1 to 10 (10 being the worst pain) to the nurse and was sent to the hospital for evaluation and treatment. The Resident suffered partial thickness chemical burns to his right buttocks extending to the posterior surface of the mid-thigh which was assessed as approximately 7% to 8% body surface. The partial thickness chemical burn required heavy irrigation with normal saline, followed by scrub with warm soapy water. The Resident stated he could not tolerate the procedure and indicated his pain level was higher than 10. He was discharged back to the facility on 09/01/23. This was for 2 of 4 residents reviewed for supervision to prevent accidents. F689: Based on observation, record review, staff, resident, Nurse Practitioner and Medical Director interview the facility failed to prevent severely cognitively impaired residents from exiting the facility through unlocked doors without supervision for 2 of 2 residents reviewed for supervision to prevent accidents. A Resident who was severely cognitively impaired, exited the building through an unlocked door on the first floor to smoke without supervision. An unidentified male intruder entered facility behind the Resident through the unlocked door of facility	F 867	appropriate plans of action for identified facility concerns.	

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and vandalized the second-floor dayroom by shattering the TV, knocking a hole in the wall, and breaking out two windows. The facility failed to repair broken windows only covering windows with cardboard and wooden board that was easily removable leaving broken windows and shards of broken glass accessible to residents and failed to complete a facility investigation. A Resident was severely cognitively impaired and exited the memory care unit through an unlocked door to the staircase. The Resident went down three flights of stairs and exited the facility through a side door. The Resident was found by a Nurse Aide (NA) when he went to his car, the resident was laying in the backseat of the NA's car asleep. The NA left the Resident in the unlocked car with the windows up, unattended in 74-degree weather while he went back inside for help.

The Administrator stated in a phone interview on 12/1/23 at 1:50 PM that she was the Administrator for the facility since February 2023 and that she QAA contact for the facility. She stated that the QAA Committee comprised of all the department managers, who met monthly, and the Medical Director who attended quarterly. The Administrator stated the QAA Committee discussed and monitored the ongoing concerns related to resident accident hazards and that she attributed the current concern with relying too heavily on the assessment of cognition and independence with ADL for Resident #1 which may have led staff to place more attention on his independence.