DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/06/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055201	A. BUILDING _____ B. WING _____	C 08/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKTON NURSING CENTER	4545 SHELLEY COURT STOCKTON, CA 95207

acceptable POC 8/30/21 AEFS

(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 The following reflects the findings of the California Department of Public Health during an abbreviated survey for the investigation of facility reported incident #CA00740781. Representing the Department of Public Health: Health Facilities Evaluator Nurse, 42813. The inspection was limited to the specific facility reported incident investigated and does not represent the findings of a full inspection of the facility.	F 000	**F000 Initial Comments** "This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Stockton Nursing and Rehab Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	BIC 8/30/21
F 689 SS=G	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 and record review, the facility failed to provide monitoring and supervision to ensure safety of six residents (Resident 1, Resident 2, Resident 3, Resident 5, Resident 6, Resident 8) in a sample of 8 residents identified at risk for elopement (an act or instance when a cognitively impaired person leaves a safe area or premises unsupervised) when: 1.Resident 1 eloped and was found in a homeless shelter with altered mental status,	F 689	**F 689 Free of Accident Hazards/Supervision/Devices** 1.Resident 1 returned to the facility from the acute on 6/19/21. Facility scheduled a resident companion (1:1 supervision) with resident for AM and PM shift (16 hours a day) starting 6/20/21. Facility placed a new wander guard bracelet on resident 1 on 6/19/21. Maintenance Director installed nine Ring security cameras with motion sensor lights around the outside of the facility on 6/21/21. See exhibit #1. Facility also purchased and installed tiles (high performance GPS finder device) on each resident's wheelchair who are on high risk for elopement on 6/21/21. See exhibit #2. Facility obtained a bid from ADT Commercial to install ten HD security cameras outside of facility on 7/16/21. See exhibit #3. Facility received a bid from Stanley Healthcare to upgrade the wander guard system throughout the facility and bid	8/30/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 8/30/21

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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F 689	Continued From page 1 dehydrated and with urinary tract infection (UTI) 3 days later. 2. Staff failed to monitor the application and functioning of wanderguard (a monitoring device which beeps when residents go out of the building) bracelets for Resident 5, Resident 6, and Resident 8. 3. Staff failed to include Resident 2 and Resident 3 with wanderguards into the Elopement log binder for monitoring and have a Medical Doctor (MD) order for Resident 2 and 3. These failures resulted in Resident 1's elopement which caused harm when she experienced dehydration and possible exposure to extreme heat and had the potential for elopement of Resident 2, Resident 3, Resident 5, Resident 6, and Resident 8. Findings: 1.A review of Skilled Nursing Facility Admission Record (SNFAR) indicated, Resident 1 was admitted to the facility in February 2020, with diagnoses including stroke (a medical condition in which poor blood flow to the brain causes cell death) and muscle weakness. A review of the Minimum Data Set (MDS; an assessment tool) dated 6/4/2021, indicated Resident 1 has a Brief Interview of Mental Status (BIMS; an assessment tool in assessing mental cognition) score of 5 which indicated Resident 1 was cognitively impaired. A review of the Medical Doctor's (MD 1) order for Resident 1 dated 4/13/2020, indicated to "monitor wanderguard (a monitoring device which alarms when resident goes out of the building) placement everyday shift."	F 689	was approved on 7/19/21. See exhibit #4. Installation date for the new "Wander Guard Blue" system will be 11/1/21. Facility staff checked functionality and alarm of the current wander guard system Q shift starting 6/21/21 and moving forward. A wander guard tag reader (tester) wasc purchased on 6/22/21 to test wander guard monitors Q shift by the license nurses. See exhibit #5. LN 4 switched her status from full time to on call on 8/17/21. A wander guard policy was developed on 8/27/21. See exhibit #6. Director of Nursing (DON) reviewed other residents with risk of elopement on 6/21/21 and created an elopement binder (a tool) identifying those residents who have a high risk of elopement and wander guard monitor on. Each station has a copy of the binder. No other residents were affected by this deficient practice. The DON conducted re-education to the license nurses and staff on 6/17/21and 8/27/21 about elopement, safety, and accident prevention. Administrator conducted re-education to staff members on 6/18/21 about elopement, codes, and safety as well. The administrator conducted re-education to department managers on 8/19/21 of daily checks of the wander guard functionality. The new wander guard system company will inservice the Maintenance Director after installation on 11/1/21 and he will then educate staff on use and functionality. During daily risk management meeting, the Interdisciplinary Team (IDT) will review the elopement assessment for any new resident	8/30/21

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F 689	Continued From page 2 A review of the facility's incident report on 6/17/21 at 4:54 pm indicated Resident 1 eloped on 6/16/2021 (did not give exact time). The report indicated Resident 1 was discovered missing in the afternoon (early evening) of 6/16/2021. A review of the Nurses' Notes dated 6/16/2021 at 1345, Licensed Nurse (LN) 1 indicated Resident 1 was last seen in the resident's bathroom at 6/16/2021 at 1:30 p.m. to 1:45 p.m. by the CNA. A review of the Nurses' notes at 6/16/2021 at 22:52 p.m., LN 5 indicated Resident 1 was discovered missing on 6/16/2021 at 10:30 p.m., during nurse endorsement at shift change. A review of the Nurses' Notes dated 6/17/2021 at 17:11 p.m. (late entry for 6/16/2021), indicated LN 4 did not monitor Resident 1 and the functionality of the wanderguard during her shift. In an interview with the Director of Nursing (DON) on 6/18/2021 at 11:30 a.m., the DON stated that the Staff realized Resident 1 was missing during evening shift report on 6/16/2021 at 10:30 p.m., and that the resident was still missing. The DON also stated that Resident 1 had a wanderguard on when she eloped. During a concurrent interview and record review of the Medication Administration Record (MAR) for the month of June with Licensed Nurse 1 (LN1) on 6/18/2021 at 12 p.m., Resident 1's wanderguard bracelet was noted to be checked daily from June 1 to June 16, 2021. LN 1 stated Resident 1 was wearing a wanderguard bracelet when she checked Resident 1 on 6/16/21 at 8 a.m.	F 689	If the new resident has a high risk for elopement, the ADON/designee will obtain an MD order for wander guard bracelet/monitor. The license nurse will place the wander guard monitor on the resident. The MRD/designee will include the resident in the elopement binder. The license nurses will conduct Q shift checks for each elopement risk resident. Medical Records Director/Designee will conduct audits, using the MAR, Q shift checks daily and report any gaps in the shift checks to the DON. The DON will address and correct the issue right away. MRD/designee will log the findings of the daily audit in a report and give the report to the DON. The DON will report on the missing documentation/gaps in a log to the QA Committee each month for the next three months. The QA committee will review and evaluate as needed. The Maintenance Director/designee will check the wander guard system daily and monitor using the log found in TELS (a tracking system report). The Manager of the Day (MOD) will conduct the daily checks of the wander guard system on the weekends and will note the findings in the log. The Administrator will be notified if there is an issue. The Administrator will report the log to the QA committee monthly for the next three months. The QA committee will review and evaluate as needed. 2.A. Resident 5 was sent to the acute on 7/10/21. Director of Nursing (DON) reviewed other residents with risk of elopement on 6/21/21	8/30/21

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F 689	Continued From page 3 During a document request with the Director of Nursing (DON) on 6/18/2021 at 1:10 p.m., the DON stated he will ask their Nurse Consultant for a policy on monitoring the wanderguard. A record review on the Emergency Documentation, dated 6/19/2021 at 4:45p.m. at the Emergency Room in a General Acute Care Hospital (GACH), MD 2 indicated that Resident 1 presented to the Emergency room with altered mental status and diagnosed with dehydration (lack of total body water with an accompanying disruption of the metabolic process) and urinary tract infection (UTI). The Complete Blood Count (CBC) results indicated Resident 1 had a white count of 13.7 thousand/unit liter (a measuring unit; normal values at 4-10). The Basic Metabolic Panel (BMP), dated 6/19/2021, indicated an elevated value (32.3) of Blood Urea Nitrogen (BUN, a measure to evaluate kidney function and fluid balance; normal values at 9.8 to 20.1) and a potassium level of 3.1 mmol/L (a unit of measure; normal value at 3.5 to 5.1). MD 2 indicated the low potassium level was indicative of dehydration. The urinalysis results, dated 6/19/2021, indicated moderate presence of blood in the urine and moderate presence of leukocyte esterase (presence of white blood cells which indicate infection). MD 2 indicated the urinalysis results indicated urinary tract infection. During an interview with the SSD on 6/29/2021 at 2:40 p.m., SSD stated that Resident 1 has been wanting to return to the homeless camp. SSD also stated that the Psych MD indicated Resident 1 does not have the mental capacity to decide. SSD stated that this was the second time Resident 1 had eloped.	F 689	and created an elopement binder (a helpful tool) identifying those residents who have a high risk of elopement and wander guard monitor on. Each station has a copy of the binder. No other residents were affected by this deficient practice. The DON conducted re-education to the license nurses and staff on 6/17/21 and 8/27/21 about elopement, safety, and accident prevention. Administrator conducted re-education to staff members on 6/18/21 about elopement, codes, and safety as well. The administrator conducted re-education to department managers on 8/19/21 of daily checks of the wander guard functionality. The new wander guard system company will inservice the Maintenance Director after installation on 11/1/21 and he will then educate staff on use and functionality. During daily risk management meeting, the Interdisciplinary Team (IDT) will review the elopement assessment for any new resident. If the new resident has a high risk for elopement, the ADON/designee will obtain an MD order for wander guard bracelet/monitor. The license nurse will place the wander guard monitor on the resident. The MRD/designee will include the resident in the elopement binder. The license nurses will conduct Q shift checks for each elopement risk resident. Medical Records Director/Designee will conduct audits, using the MAR. Q shift checks daily and report any gaps in the shift checks to the DON. The DON will address and correct the issue right away. MRD/designee will log the findings of the daily audit in a report and give the report	8/30/21

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F 689	Continued From page 4 During a phone interview with LN 4 on 6/29/2021 at 3:05 p.m., LN4 indicated she was busy on 6/16/2021 and did not check the wanderguard of Resident 1. LN 4 stated, "she did not see Resident 1 that day and the CNA did not notice Resident 1." The DON confirmed there was no facility policy on wanderguard monitoring. In an email on 6/29/2021 at 3:58 pm, DON indicated that the facility has no policy on monitoring the wanderguard. In an email on 7/9/2021 at 2:05 p.m., DON indicated that the facility has no policy on monitoring the wanderguard as of 6/18/2021. During a phone interview with LN 4 on 7/9/2021 at 2:26 p.m., LN 4 confirmed LN 4 did not check Resident 1 on 6/16/2021 on her shift. LN 4 stated, "I didn't expect her to leave like that ..." 2. During a concurrent interview with the DON on 6/18/2021 at 1:30 p.m. at the DON's office and record review of the Elopement Log binder, the DON showed a one-page resident file on each of the high-risk residents for elopement. There were five residents in the binder, namely Resident 4, Resident 5, Resident 6, Resident 7, and Resident 8. a. A review of Resident 5's SNFAR indicated he was admitted in the spring of 2021 with diagnoses including traumatic subarachnoid hemorrhage (bleeding in the brain) and major depression. A review of the MDS indicated Resident 5 was cognitively impaired.	F 689	to the DON. The DON will report on the missing documentation/gaps in a log to the QA Committee each month for the next three months. The QA committee will review and evaluate as needed. The Maintenance Director/designee will check the wander guard system daily and monitor using the log found in TELS (a tracking system report). The Manager of the Day (MOD) will conduct the daily checks of the wander guard system on the weekends and will note the findings in the log. The Administrator will be notified if there is an issue. The Administrator will report the log to the QA committee monthly for the next three months. The QA committee will review and evaluate as needed. 2.B. Resident 6 had an order via MD for a wander guard placement on 6/21/21. Director of Nursing (DON) reviewed other residents with risk of elopement on 6/21/21 and created an elopement binder (a helpful tool) identifying those residents who have a high risk of elopement and wander guard monitor on. Each station has a copy of the binder. No other residents were affected by this deficient practice. The DON conducted re-education to the license nurses and staff on 6/17/21and 8/27/21 about elopement, safety, and accident prevention. Administrator conducted re-education to staff members on 6/18/21 about elopement, codes, and safety as well. The administrator conducted re-education to department managers on 8/19/21 of daily	8/30/21

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F 689	Continued From page 5 During a concurrent observation and interview with LN 1 on 6/18/2021 at 1 p.m., Resident 5 was found not wearing his wanderguard and being wheeled by the Physical Therapist back to his room. LN 1 stated Resident 5 did not have his wanderguard on. During an interview with LN 2 on 6/18/21 at 1:47 pm, LN 2 stated that he checked the wanderguard of Resident 5 at 8 am and it was working. During a concurrent interview and record review with the DON on 6/18/2021 at 2:30 pm, DON confirmed there was no MD (MD 1) order for Resident 5 and there was no documentation of wanderguard monitoring in the MAR. DON stated Resident 5 was only a high potential for elopement and that was why he has no wanderguard. A review of MD 1's order for Resident 5, dated 6/21/2021, showed "wanderguard for placement and monitoring" was ordered 3 days after the facility visit. b.A review of Resident 6's SNFAR indicated he was admitted in April 2021, with diagnoses including dementia (a group of symptoms that make it hard to remember, think clearly, make decisions, and even control emotions). A review of the MDS, indicated Resident 6 has a BIMS score of 3 which indicated severely impaired. During a concurrent observation and interview on 6/18/2021 at 2:10 p.m., LN 3 brought Resident 6 to the front door to check the functioning of the wanderguard. There was an audible alarm when	F 689	checks of the wander guard functionality. The new wander guard system company will inservice the Maintenance Director after installation on 11/1/21 and he will then educate staff on use and functionality. During daily risk management meeting, the Interdisciplinary Team (IDT) will review the elopement assessment for any new resident. If the new resident has a high risk for elopement, the ADON/designee will obtain an MD order for wander guard bracelet/monitor. The license nurse will place the wander guard monitor on the resident. The MRD/designee will include the resident in the elopement binder. The license nurses will conduct Q shift checks for each elopement risk resident. Medical Records Director/Designee will conduct audits, using the MAR, Q shift checks daily and report any gaps in the shift checks to the DON. The DON will address and correct the issue right away. MRD/designee will log the findings of the daily audit in a report and give the report to the DON. The DON will report on the missing documentation/gaps in a log to the QA Committee each month for the next three months. The QA committee will review and evaluate as needed. The Maintenance Director/designee will check the wander guard system daily and monitor using the log found in TELS (a tracking system report). The Manager of the Day (MOD) will conduct the daily checks of the wander guard system on the weekends and will note the findings in the log. The Administrator will be notified if there is an issue. The Administrator will report the log	8/30/21

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F 689	Continued From page 6 he reached the front door. During a concurrent interview and record review with the DON on 6/18/2021 at 2:20 p.m., the Medication Administration Record (MAR) for the month of June 2021 indicated, Resident 6 was being monitored for wandering behavior. DON stated there was no MD order to monitor wanderguard placement and monitoring. A review of the MD 1's order for Resident 6 dated 6/21/2021 indicated, "monitor wanderguard for functioning every shift." The order was written 3 days after the facility visit. A review of the MAR for June 2021 indicated Resident 6 was monitored starting on 6/21/2021 on the p.m. shift. c. A review of Resident 8's SNFAR indicated she was admitted in November 2020, with diagnoses including Alzheimer's disease (a progressive disease characterized by memory loss and cognitive impairment), schizophrenia (a mental disorder characterized by hallucinations[hearing voices], and disorganized thinking. A review of the MDS, indicated Resident 8 has a BIMs score of 11 which indicated moderate impairment. A review of the MD (MD 1) order for Resident 8 dated 2/13/2021 indicated "monitor for exit seeking behavior." A review of the MD 1 order, dated 2/16/2021, indicated "monitor wanderguard to right wrist for placement and functioning every shift." During a concurrent observation and interview on 6/18/2021 at 2:15 p.m., Resident 8 did not have	F 689	to the QA committee monthly for the next three months. The QA committee will review and evaluate as needed. 2.C. Resident 8 had a new wander guard bracelet placed on 6/18/21. Director of Nursing (DON) reviewed other residents with risk of elopement on 6/21/21 and created an elopement binder (a helpful tool) identifying those residents who have a high risk of elopement and wander guard monitor on. Each station has a copy of the binder. No other residents were affected by this deficient practice. The DON conducted re-education to the license nurses and staff on 6/17/21and 8/27/21 about elopement, safety, and accident prevention. Administrator conducted re-education to staff members on 6/18/21 about elopement, codes, and safety as well. The administrator conducted re-education to department managers on 8/19/21 of daily checks of the wander guard functionality. The new wander guard system company will inservice the Maintenance Director after installation on 11/1/21 and he will then educate staff on use and functionality. During daily risk management meeting, the Interdisciplinary Team (IDT) will review the elopement assessment for any new resident. If the new resident has a high risk for elopement, the ADON/designee will obtain an MD order for wander guard bracelet/monitor. The license nurse will place the wander guard monitor on the resident. The MRD/designee will include the resident	8/30/21

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F 689	Continued From page 7 her wanderguard on. DON stated that LN 1 checked her wanderguard and it was on. DON stated that Resident 8 was able to remove the wanderguard bracelet. During a concurrent interview with the DON on 6/18/2021 at 2:30 p.m. at his office, and record review of the MAR for the month of June, DON indicated Resident 8 was noted to be checked for wanderguard from June 1 to 17, 2021. There was no documentation for June 18, 2021. The DON stated that that shift was not over yet and that the LN has not documented the monitoring. DON also confirmed the facility's list does not match the current identified residents who are at-risk for elopement. A review of the MD order (MD 1) for Resident 8, dated 6/18/2021 indicated, "Resident 8 is on every 15 minutes whereabouts until wanderguard is available." A review of the documentation on "Q 15 minutes Safety Checks" on Resident 8, dated 6/18/2021 and 6/19/2021, indicated Resident 8 was monitored on 6/18/2021 and 6/19/2021 only. There was no documentation for Resident 8's Q 15-minute checks monitoring from 6/20/2021 to 6/29/2021. In an email from the DON dated 7/9/2021, DON indicated "wanderguard was placed on the patient on 6/29/21 at 1 pm." A review of the facility's policy titled "Wandering, Unsafe Residents" dated Quarter 3, 2018, indicated " ...the staff will identify residents who are at risk for wandering ..."	F 689	in the elopement binder. The license nurses will conduct Q shift checks for each elopement risk resident. Medical Records Director/Designee will conduct audits, using the MAR, Q shift checks daily and report any gaps in the shift checks to the DON. The DON will address and correct the issue right away. MRD/designee will log the findings of the daily audit in a report and give the report to the DON. The DON will report on the missing documentation/gaps in a log to the QA Committee each month for the next three months. The QA committee will review and evaluate as needed. The Maintenance Director/designee will check the wander guard system daily and monitor using the log found in TELS (a tracking system report). The Manager of the Day (MOD) will conduct the daily checks of the wander guard system on the weekends and will note the findings in the log. The Administrator will be notified if there is an issue. The Administrator will report the log to the QA committee monthly for the next three months. The QA committee will review and evaluate as needed. 3.Residents 2 and 3 were added to the elopement log binder on 6/18/21. Both residents were given new wander guard bracelets on 6/21/21. Resident 2 was reassessed and MD orders for wander guard were given on 6/21/21. Director of Nursing (DON) reviewed other residents with risk of elopement on 6/21/21 and created an elopement binder (a helpful tool) identifying those residents who have a	8/3/21

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055201	A. BUILDING _____ B. WING _____	C 08/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKTON NURSING CENTER	4545 SHELLEY COURT STOCKTON, CA 95207

(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 689	Continued From page 8 Resident 5 and Resident 8 were observed without wanderguard bracelets. Resident 5 and Resident 6 did not have an MD order for monitoring the wanderguard. 3, During a facility visit on 6/18/2021 at 12:15 a.m. with LN1, Resident 2 and Resident 3 were found wearing a wanderguard bracelet, but not included in the Elopement Log binder. Resident 2 was found with a non-functioning wanderguard bracelet. Resident 3 did not have an MD order for the wanderguard placement and monitoring. a. A review of Resident 2's Skilled Nursing Facility Admission Record (SNFAR) indicated Resident 2 was admitted in September 2014, with diagnoses including severe cognitive impairment and schizophrenia (a mental disorder characterized by hallucinations [hearing voices] and disorganized thinking). A review of Resident 2's MD (MD3) order dated 11/09/2019 indicated, "may have wanderguard bracelet due to risk of wandering." During a concurrent observation and interview on 6/18/2021 at 12:15 p.m., LN 1 brought Resident 2 to the front door, the resident went out of the front door with the wanderguard on her, but there was no audible alarm heard. LN 1 stated the wanderguard was not functioning. During an interview with the DON on 6/18/2021 at 12:20 p.m., DON stated that Resident 2 is one of the residents deemed by the Interdisciplinary Team (IDT) for recommendations to MD to discontinue her wanderguard order as she does not have the risk for elopement.	F 689	high risk of elopement and wander guard monitor on. Each station has a copy of the binder. No other residents were affected by this deficient practice. The DON conducted re-education to the license nurses and staff on 6/17/21and 8/27/21 about elopement, safety, and accident prevention. Administrator conducted re-education to staff members on 6/18/21 about elopement, codes, and safety as well. The administrator conducted re-education to department managers on 8/19/21 of daily checks of the wander guard functionality. The new wander guard system company will inservice the Maintenance Director after installation on 11/1/21 and he will then educate staff on use and functionality. During daily risk management meeting, the Interdisciplinary Team (IDT) will review the elopement assessment for any new resident. If the new resident has a high risk for elopement, the ADON/designee will obtain an MD order for wander guard bracelet/monitor. The license nurse will place the wander guard monitor on the resident. The MRD/designee will include the resident in the elopement binder. The license nurses will conduct Q shift checks for each elopement risk resident. Medical Records Director/Designee will conduct audits, using the MAR, Q shift checks daily and report any gaps in the shift checks to the DON. The DON will address and correct the issue right away. MRD/designee will log the findings of the daily audit in a report and give the report to the DON. The DON will report on the missing documentation/gaps in a log to the	8/30/21

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F 689	Continued From page 9 During an interview with the DON on 6/18/2021 at 1:45 p.m., DON stated that there was no IDT documentation on Resident 2's re-evaluation on wanderguard placement. During a concurrent interview and record review with the DON on 6/18/2021 at 2:20 p.m., the Medication Administration Record (MAR) for the month of June 2021 indicated Resident 2's wanderguard was noted to be checked from June 1-18, 2021 as functioning. DON stated that he does not know what time the wanderguard was checked, and maybe was working at that time. DON stated that the documentation indicated the wanderguard was checked. DON confirmed that Resident 2 was not included in the Elopement Log binder. b. A review of Resident 3's SNFAR indicated she was admitted in November 2016 with diagnoses including dementia (a group of symptoms that make it hard to remember, think clearly, make decisions, and even control emotions). A review of the MDS, indicated Resident 3 has a BIMS score of 3 which indicated severely impaired. During a concurrent observation and interview with LN 1 on 6/18/2021 at 12:35 p.m., Resident 3 was found standing in the lobby wearing a wanderguard. LN 1 led Resident 3 to the main door and there was an audible alarm. During a concurrent interview with the DON on 6/18/2021 at 1:30 p.m. in his office and record review of the Elopement Log binder, the DON confirmed Resident 3's file was not included in the Elopement Log binder. During a concurrent interview with DON on	F 689	QA Committee each month for the next three months. The QA committee will review and evaluate as needed. The Maintenance Director/designee will check the wander guard system daily and monitor using the log found in TELS (a tracking system report). The Manager of the Day (MOD) will conduct the daily checks of the wander guard system on the weekends and will note the findings in the log. The Administrator will be notified if there is an issue. The Administrator will report the log to the QA committee monthly for the next three months. The QA committee will review and evaluate as needed.	8/30/21

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F 689	Continued From page 10 6/18/2021 at 1:30 p.m. and record review of the MD 3's order for Resident 3, DON confirmed there is no MD order to monitor wanderguard for Resident 3. A review of MD 3's order for Resident 3 on 6/21/2021 indicated, "monitor wanderguard for placement every shift." The order was written 3 days after the facility visit on 6/18/2021. A review of the care plan dated 6/22/2021 indicated "Resident has wanderguard for wandering behavior." The Care plan was written 4 days after the facility visit on 6/18/2021. A review of the facility's policy titled "Wandering, Unsafe Residents" dated Quarter 3, 2018, indicated " ...the staff will identify residents who are at risk for wandering ..." The DON confirmed there was no facility policy on wanderguard monitoring. In an email on 6/29/2021 at 3:58 pm, DON indicated that the facility has no policy on monitoring the wanderguard. In an email on 7/9/2021 at 2:05 p.m., DON indicated that the facility has no policy on monitoring the wanderguard as of 6/18/2021.	F 689		