STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555854	A. BUILDING _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS The following represents the findings of the California Department of Health during the investigation of a Facility Reported Incident. Facility Reported Incident number: CA00779973 Representing the Department: Health Facilities Evaluator Nurse: 41511 The inspection was limited to the Facility Reported Incident investigated and does not represent the findings of a full inspection of the facility. One deficiency was identified for Facility Reported Incident number: CA00779973.	F 000	Please accept this Plan of Correction as our Credible Allegation Package. The deficiencies will be corrected as specified and they will be monitored to prevent recurrence no later than 5/14/22 Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed as required by statute set forth in Code of Federal Regulations, Title 42, Section 489.12; State operations manual, Section 2612; and California Health and Safety Code, Section 1280 and the facility does not waive its right to contest or pursue an appeal of the deficiency as allowed under Federal and State Law. RP (Initials)	
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to provide the appropriate care and supervision to maintain the safety and highest practical physical, mental, and psycho-social wellbeing for 2 out of 16 sampled residents (Resident 8 and Resident 9) diagnosed with dementia (impairment of brain functions such as memory loss forgetfulness, limited social skills, loss of judgment, and impaired thinking). By failing to: 1. Provide supervision to prevent Resident 8 and Resident 9 from wandering into the rooms of other residents. 2. Implement individualized care plans for Resident 8 and Resident 9 who had identified	F 744	F744 – Treatment/Service for Dementia CFR(s): 483.40(b)(3) CORRECTIVE ACTION On 4/13/22, Resident-8 and Resident-9 were provided supervision and monitoring for wandering into the rooms of other residents. Individualized care plans were implemented Revised:	5/14/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kay Pella — Raymond Pellicer — TITLE: Administrator — (X6) DATE: 5/19/22

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 744	Continued From page 1 wandering and exit seeking behavior. 3. Update Resident 8 and Resident 9 ' s care plans after episodes of unsafe wandering behaviors. These deficient practices place residents with dementia at risk for injury from entering an unfamiliar potentially hazardous environment, potentially ingesting food from an unapproved diet or a toxin and place all 85 facility residents at risks for altercations and at risk for a violation of privacy and misappropriation of personal property. Findings: A review of Resident 8 ' s face sheet indicated the facility admitted the resident on 12/20/2021 with diagnoses that included dementia, anxiety disorder, and schizophrenia (mental disorder that affects a person ' s ability to think, feel, and behave clearly). A review of Resident 8 ' s Minimum Data Set (MDS: a standardized data collection tool used to assess thought processes and functional ability) dated 03/17/2021, indicated the resident was moderately impaired in making decisions regarding tasks of daily life. The MDS indicated the resident showed symptoms of depression and hopelessness "nearly every day". The MDS indicated the resident required limited assistance with walking. The MDS indicated the resident was unable to participate in a brief interview for mental assessment (BIMS) assessment. A review of Resident 8 ' s care plan for "visual impairment: highly impaired- object identification in question, but eyes appear to follow objects" dated 12/23/2021, indicated a goal of the resident not falling. The care plan indicated interventions to be taken by the facility staff included keeping furniture/clutter free of path, orienting to furniture placement, and keeping the call light within reach.	F 744	for Resident-8 and Resident-9 identified with wandering and exit seeking behavior on 5/17/22 by the charge nurses. Resident 8 and 9's care plans were updated on 4/13/22 for episodes of wandering behavior to prevent episodes or violation of privacy on others. **IDENTIFYING OTHER RESIDENTS AT RISK & CORRECTIVE ACTION** On 5/9/22, the Director of Nursing (DON), Quality Assurance (QA) Nurse and RN supervisor reviewed and reassessed residents with diagnosis of dementia for risk of elopement. One resident was identified with wandering behavior and risk for elopement; the care plan was updated for the one resident identified. On 5/9/22, department supervisors conducted room rounds to assess concerns including privacy or misappropriation of personal property by other residents. No other findings was identified. **SYSTEMIC CHANGES** To prevent recurrence of the same deficiency, the DON provided education to licensed staff and certified nurse assistants (CNAs) on 5/6/22 and 5/9/22, discussing the facility's policy and appropriate care for wandering residents or exit seeking behavior, including provide staff supervision, implementing or updating care plans upon change of condition and quarterly review to ensure those residents are provided a safe	

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F 744	Continued From page 2 The care plan did not indicate what interventions would be taken to address visual impairment when walking around facility. A review of Resident 8 ' s care plan for "Cognition problem related to short term memory problem, long term memory problem, dementia, and poor decision making" dated 12/23/2021, indicated goals of resident knowing name when called and the resident responding appropriately to verbal communication. The care plan indicated interventions to be taken by the facility staff included encourage out of room and attend activity, reality orientation daily and when needed, and using simple commands. The care plan did not indicate the specific dementia behaviors displayed by Resident 8 or interventions to address the behaviors identified. A review of Resident 8 ' s nurse ' s notes dated 01/31/2022 at 10:27 PM, indicated the resident was on monitoring for wandering behavior. The notes did not indicate where Resident 8 was wandering or the details of Resident 8 ' s wandering behavior. A review of Resident 8 ' s Interdisciplinary Team (IDT) meeting notes dated 01/31/2022, indicated the meeting was held "relating to resident's behavior of exit seeking attention and attempts to exit door. Aimlessly wanders without purpose, unable to follow reminders consistently. Requires constant redirection." The notes indicated the resident was unable to comprehend risk and consequences associated with leaving and the resident ' s sister was made aware. The notes indicated a wander guard bracelet was ordered. The IDT notes indicated "Resident will be monitored location hourly for safety and anticipate needs based upon wandering behavior." The IDT notes indicated Resident 8 would be offered activities of choice.	F 744	environment free from injury. During new hire orientation, the Director Staff Development (DSD) or designee will provide dementia care training for all new hires. In-services will be provided by the DSD or designee to staff, detailing dementia care, subsequently every month and as needed. Residents will be assessed for elopement risk upon their admission, quarterly thereafter and as needed. **MONITORING EFFECTIVENESS** Licensed nurses will conduct shift to shift huddle communication daily to inform staff of any changes in behavior of wandering and exit seeking behaviors. Behaviors are monitored and documented in behavior monitoring in the Medication Administration Sheet. The Interdisciplinary Team will monitor monthly for any trends for any behavior management; findings will be reported to QAPI Committee for review and actions. Medical records will conduct scheduled audits on changes of condition and behavior management and will report any audit findings to the DON or designee. Any trends and findings will be reported by the DON at the monthly and quarterly Quality Assurance committee meeting for policy review and analysis.	

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F 744	Continued From page 3 A review of Resident 8 ' s care plan for "Wandering behavior noted walking around the facility" dated 01/31/2022, indicated a goal of redirecting resident behavior daily. The care plan indicated interventions to be taken by the facility staff included giving emotional support, leaving the resident, and returning when calm, and encouraging activities. The care plan did not indicate where in the facility the resident would wander or what interventions to take if the resident wandered in another resident ' s room. A review of Resident 8 ' s care plan for "At risk for injuries secondary to elopement" dated 01/31/2022. Indicated a goal of Resident 8 not eloping from the facility. The care plan indicated interventions to be taken by the facility staff included monitoring the resident ' s location with visual checks at least every 2 hours, keeping a hazard free environment, and applying a wander guard bracelet. The care plan did not indicate the specific A review of Resident 8 ' s SBAR communication form dated 01/31/2022, indicated Resident 8 was walking around the facility. The SBAR did not indicated where in the facility the resident was wandering. The SBAR indicated the resident was to have hourly elopement monitoring and a wander guard. A review of Resident 8 ' s nurse ' s notes dated 02/02/2022 at 10:31 AM, indicated "patient still have wonder behavior, walking into patient ' s room and taking items do not belong to him. Unable to redirect. Patient will show signs of agitation if staff try to redirect him. Most item return back to its original place". A review of Resident 8 ' s care plan, revealed the care plan and interventions were not updated on 02/02/2022 after Resident 8 wandered into another resident ' s room and took the other	F 744		

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F 744	Continued From page 4 resident ' s personal belongings. A review of Resident 8 ' s IDT meeting notes revealed no IDT meeting was held regarding Resident 8 wandering into other resident ' s rooms on 02/02/2022. A review of Resident 8 ' s nurse ' s notes dated 02/03/2022 at 11:14 AM, indicated "patient will walk in and out other patient ' s room and grabbing items do not belong to him. Unable to redirect. Ativan IM injection was ordered". A review of Resident 8 ' s care plan, revealed the care plan and interventions were not updated on 02/03/2022 after Resident 8 wandered into another resident ' s room and took the other resident ' s personal belongings. A review of Resident 8 ' s IDT meeting notes revealed no IDT meeting was held regarding Resident 8 wandering into other resident ' s rooms on 02/03/2022. A review of Resident 8 ' s SBAR dated 04/07/2022 (no time), indicated Resident 8 had "Behavioral tendency of roaming around in other resident ' s room". The SBAR indicated interventions to keep the resident safe included one to one monitoring for safety, redirection of activities provided, and keeping environment safe by locking away sharp objects. A review of Resident 8 ' s care plan for verbal altercation with another resident dated 04/07/2022, indicated interventions to be taken by the facility staff included one on one supervision, and provide activities of choice. A review of Resident 8 ' s care plan for wandering behavior, revealed the care plan had not been updated on 04/07/2022. The care plan indicated the last date of update was on 01/31/2022. A review of Resident 8 ' s nurse ' s notes dated 04/08/2022 at 05:36 AM, indicated "Resident on monitoring due to behavioral tendency of roaming	F 744		

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F 744	Continued From page 5 around in other resident ' s room". A review of Resident 8 ' s care plan for wandering behavior, revealed the care plan had not been updated on 04/08/2022. The care plan indicated the last date of update was on 01/31/2022. A review of Resident 9 ' s face sheet indicated the facility admitted the resident on 03/07/2022 with diagnoses which included hypertensive (high pressure) heart disease, anxiety disorder and dementia. A review of Resident 9 ' s H&P dated 03/08/2022, indicated the resident did not have the capacity to understand and make decisions. A review of Resident 9 ' s MDS dated 03/14/2022, indicated the resident had a BIMS score of 3 out of 15, indicating the resident was not cognitively intact. A review of Resident 9 ' s care plan for "Dementia" dated 03/07/2022, indicated goals which included being able to find room, know name when called, and ability to know name when called. The care plan indicated interventions to be taken by the facility staff included simple question commands, encourage out of room activity, and reality orientation daily. A review of Resident 9 ' s care plan for "Resident will participate in activities of choice as, coffee, social, bingo, movies, etc." dated 03/08/2022, indicated the resident enjoyed attending group activities and was to be provided with a monthly calendar and invited to activities. The care plan did not indicate which activities were of interest to the resident or what activities were available for dementia related cognitive deficits. A review of Resident 9 ' s IDT meeting minute notes dated 03/08/2022, did not indicate Resident 9 ' s wandering was addressed during the meeting. A review of Resident 9 ' s IDT meeting minute	F 744		

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F 744	Continued From page 6 notes dated 03/15/2022, did not indicate Resident 9 ' s wandering was addressed during the meeting. A review of Resident 9 ' s SBAR communication form dated 03/22/2022, indicated the resident was at risk for elopement related to wandering and trying to open any door. The notes indicated a wander guard was placed on the resident ' s arm. A review of Resident 8 ' s nurse ' s notes dated 03/22/2022 at 8:53 PM, indicated the resident was having wandering behavior and a wander guard was placed on the resident "in AM shift". The notes stated the resident was ambulating in the hallways. A review of Resident 9 ' s care plan for "Risk for injuries secondary to elopements and wandering behaviors" dated 03/22/2022, indicated a goal "staff will recognize if resident is high risk of elopement". The care plan indicated interventions to be taken by the facility staff included elopement assessment on admission and quarterly, explain intended use of "device" to resident and or family replace batteries in "device", monitor presence of "device", and monitor expiration of "device. A review of Resident 9 ' s nurse ' s notes dated 03/26/2022 at 11:32 PM, indicated "Resident roaming in the halls but not aimlessly". A review of Resident 9 ' s nurse ' s notes dated 04/11/2022 at 4:53 PM, indicated the resident was on behavioral monitoring for "tendency to roam into other residents ' rooms". The notes did not indicate when the behavior began, how often it occurred. The notes indicated the resident would be redirected upon entering other resident rooms. A review of Resident 9 ' s care plan for "Risk for injuries secondary to elopements and wandering behaviors", revealed the care plan had not been	F 744		

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F 744	Continued From page 7 updated after the identified behavior of roaming into other resident ' s rooms on 04/11/2022. A review of Resident 9 ' s nurse ' s notes dated 04/12/2022 at 5:53 AM, indicated on 04/11/2022 during the "11/7" the resident was on behavioral monitoring for tending to roam into other resident ' s rooms. A review of Resident 9 ' s nurse ' s notes dated 04/13/2022 at 3:38 AM, indicated the resident was on behavioral monitoring for tending to roam into other resident ' s rooms. During an observation on 04/07/2022 at 9:15 AM, Resident 8 was observed walking in the hallway from the South Station towards the North Station. Other residents were observed walking in the hallway and staff was observed walking in and out of resident rooms. No staff observed with the resident. During an observation on 04/07/2022 at 10:00 AM, Resident 9 was observed walking in the hallway in the South station. Staff was observed walking in and out of resident rooms. No staff observed with the resident. During an interview on 04/07/2022 at 10:40 AM, Resident 6 who had a BIMS score of 11 out of 15, indicating the resident had mild cognitive impairment, stated confused residents often wandered into the resident ' s room. Resident 6 did not understand how the residents got by the nurses since Resident 6 ' s room was right next to the nurse ' s station. "They must not be watching". Resident 6 would tell the wandering residents to get out. Resident 6 stated the facility staff was aware of this and did not do anything to prevent it. During an interview on 04/07/2022 at 10:50 AM, Resident 7 who had a BIMS score of 15 out of 15, indicating the resident was cognitively intact, stated during the week of 03/27/2022 a resident	F 744		

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F 744	Continued From page 8 that resembles "Kanye West" (later identified as Resident 8) entered the resident ' s room and threatened to hit the resident with a stick. Resident 7 stated the incident was not reported because the facility was aware of confused residents entering other residents ' rooms every day and at all hours and nothing had been done. Resident 7 stated it was not only a violation of privacy but also a safety concern; especially for residents who could not speak up to advocate for themselves. Resident 7 stated Resident 9 had gone into his room and tried to pull the curtain while the resident was changing. The resident stated the nurse was called to remove Resident 9. Resident 7 stated the facility did not know how to control the residents with cognitive deficits and allowed residents with cognitive deficits to wander in other resident ' s rooms. Resident 7 did not remember the date of the incident with the female resident, and said it was not an isolated incident. During an interview on 04/07/2022 at 11:15 AM, Certified Nursing Assistant 2 (CNA 2) stated the facility had quite a few residents that wandered throughout the facility and would often enter other resident ' s rooms. CNA 2 stated the only interventions taken would be redirection. CNA 2 stated Resident 9 often wandered in other resident ' s rooms and it was a violation of resident ' s rights to privacy and a safety concern for all residents but not much could be done to prevent it. During an interview on 04/07/2022 at 1:07 PM, Licensed Vocational Nurse 3 (LVN 3) stated the facility had residents with dementia that wandered into other resident ' s rooms. LVN 3 stated Resident 9 was one of the residents known to go into other resident ' s rooms and stated, "but we can ' t do anything about it, they have rights". LVN 3 then stated, "we just have to redirect them, that	F 744		

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F 744	Continued From page 9 ' s all". LVN 3 the wandering residents were violating the rights of other residents, but the facility could not prevent it. LVN 3 stated there was a "safety risk" for all residents especially the wandering residents. LVN 3 stated the residents could fall in another resident ' s room because of the unknown environment, take or eat something they shouldn ' t, or hurt or be hurt by other residents. LVN 3 stated the facility staff could not always watch the wandering residents and that is why they would get in other resident ' s rooms. LVN 3 stated the nurses could only watch and redirect, but the nurses could not always watch the wandering resident ' s, especially when providing care to other residents. During an interview on 04/07/2022 at 1:25 PM, LVN 1 stated Resident 8 and Resident 9 wandered into other residents ' rooms "all the time". LVN 1 confirmed having caught both Resident 8 and Resident 9 in Resident 7 ' s room. LVN 1 stated the only intervention for Resident 8 and Resident 9 was redirection. LVN 1 stated redirection was not effective. LVN 3 stated the nurses tried to be vigilant and prevent Resident 8 and Resident 9 from wandering into other residents ' room, but it was "unpreventable if providing care" and "happens often". LVN 1 stated there was no system in place in the facility to prevent residents from wandering onto other resident ' s rooms other than redirection. During an interview on 04/07/2022 at 2:12 PM, the Director of Nursing (DON) stated it was very hard to supervise the wandering resident ' s and the facility could not provide sitters for all resident ' s with identified wandering behavior. The DON stated the only thing the facility staff could do was to keep an eye on resident ' s who wander and redirect. The DON stated if the nurses were providing care residents could not be supervised	F 744		

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F 744	Continued From page 10 and therefore residents wandering into other rooms "does happen and can happen; we just have to redirect". The DON stated the facility had two residents that would go into other resident ' s rooms (Resident 8 and Resident 9). The DON stated the only interventions the facility had in place for Resident 8 and Resident 9 was redirection. The DON stated the only other thing the facility could do was transfer Resident 8 out to another facility. The DON stated Resident 8, and Resident 9 were violating the privacy of other residents and posed a safety concern and could get hurt. The DON stated the facility did accept residents with a dementia diagnosis and wandering was a behavior associated with dementia because the residents were forgetful and walked around aimlessly without purpose. The DON stated since the wandering behavior was expected the facility should plan to have residents with wandering behaviors. The DON stated the facility was providing sitters for Resident 8 and Resident 9 on 04/07/2022 because the surveyor was in the facility and stated, "I can only do what I can" and "I will look into transferring Resident 8". During an interview on 04/07/2022 at 3:30 PM, the administrator stated he was aware of residents wandering in other rooms. Stated "I get it" regarding safety concerns and violating residents ' rights to privacy. The administrator repeated "I get it" and stated privacy and safety issues were present if residents were allowed to wander in other resident ' s room. The administrator stated Resident 7 ' s allegation against Resident 8 would be investigated and reported. During an interview on 04/13/2022 at 9:15 AM, the administrator stated Resident 7 was interviewed and reported to the administrator that	F 744		

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F 744	Continued From page 11 Resident 8 entered Resident 7 ' s room and threatened to kill Resident 7. The administrator then stated, "I get it", wandering residents need to stay out of other residents rooms. During an interview on 04/13/2022 at 10:22 AM, the activities assistant (AA) stated the facility provided "some" dementia training, but the AA had "self-educated" and downloaded apps to learn about dementia. The AA stated activities in place for dementia residents included doing things with their hands, puzzles, playing music, and drum sets. The AA stated the dementia residents had a short attention span and would wander off from activities. The AA stated Resident 8, and Resident 9 did not have any activities "specifically targeted" towards their interests and stated having them sit and do a puzzle was challenging "because as soon as they see a lot of people going out, it redirects their attention". During an interview on 04/13/2022 at 10:34 AM, CNA 3 stated he worked as admission coordinator with the facility until 04/08/2022. CNA 3 stated the role of admission coordinator included the resident ' s insurance was active. CNA 3 stated the Director of Nursing (DON) was responsible for assessing all incoming residents to ensure the facility could provide the care needed. CNA 3 stated the DON reviewed Resident 8 and Resident 9 ' s medical records form the transferrign facility and was aware of the residents ' behaviors. CNA 3 stated the DON approved their admissions. CNA 3 stated Resident 8 and Resident 9 were known for wandering and the facility staff knew to redirect the residents. CNA 3 stated Resident 8 and Resident 9 wandering into other resident ' s rooms could not be avoided when nurses were providing care. CNA 3 stated the CNAs did not have access to the resident ' s care plans and	F 744		

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	555854	A. BUILDING _____ B. WING _____	C 04/14/2022

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F 744	Continued From page 12 interventions were based on what the nurses told the CNAs to do and were told to redirect Resident 8 and Resident 9. CNA 3 did not recall when the facility provided the last dementia in service. During an interview o 04/13/2022 at 10:50 AM, LVN 5 stated wandering behaviors were expected in residents diagnosed with dementia. LVN 5 stated wander guards were placed on wandering residents to prevent them from leaving the facility and when needed one on one supervision. LVN 5 stated wandering residents would at times go into other resident ' s rooms and needed to be redirected and provided activities. LVN 5 stated wandering residents were at risk for being accused of taking things, eating or ingesting something they shouldn ' t such as a solid food which the residents could choke on. LVN 5 stated Resident 8 was visually impaired and was at "very high" risk for falling. LVN 5 stated an altercation could also occur because residents would get upset when other residents entered their rooms. LVN 5 did not know what the process was for assessing for elopement or wandering behaviors. LVN 5 stated the Registered Nurses (RNs) were responsible for implementing and updating care plans. LVN 5 did not recall when the last dementia training was. During a concurrent interview and record review on 04/13/2022 at 11:13 AM, registered Nurse Supervisor 1 (RNS 1) reviewed Resident 8 ' s care plan and stated the care plan was not individualized to the resident. RNS 1 stated Resident 8 was only active for certain periods of time and the times were very predictable. RNS 1 stated that information should have been added to the care plan and interventions adjusted accordingly. RNS 1 confirmed Resident 8 ' s care plan had not been updated since 01/31/2022 and was not resident specific. RNS 1 reviewed	F 744		

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F 744	Continued From page 13 Resident 9 ' s care plan and stated the care plan was not individualized to the resident. RNS 1 stated Resident 9 could always be found in a set location by the physical therapy room. RNS 1 stated Resident 9 like the exit located next to the physical therapy room and would try to go out the door but the alarm would scare the resident back into the facility. RNS 1 stated that information should have been added to the care plan and interventions adjusted accordingly. RNS 1 confirmed Resident 8 ' s care plan had not been updated since 03/22/2022 and was not resident specific. RNS 1 stated residents with dementia diagnoses needed to be assessed upon admission and resident specific dementia behaviors identified. RNS 1 stated all licensed nurses had access to implementing and updating the care plans. During an interview on 04/13/2022 at 12:36 PM, the Director of Staff Development (DSD) had been employed at the facility for two months and had provided one training for dementia in March and did not in service the night shift. The DSD confirmed all employees were not in serviced and stated it was important to ensure all facility staff were trained on how to care for residents with a dementia diagnosis. During an observation on 04/13/2022 from 12:30 PM to 12:35 PM, Resident 8 was observed in an outdoor patio located on the south end of south station next to rooms 40 AND 41. No staff was observed supervising the resident. The outdoor patio was enclosed with a concrete wall with ledge approximated 3-4 ' tall, on the ledge was a white metal fence approximately 3 ' high. The patio had one gate with a padlock leading to the parking lot. During an interview on 04/13/2022 at 1:45 PM, CNA 4 was assigned as the sitter for Resident 8.	F 744		

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F 744	Continued From page 14 CNA 4 stated the role included observing the resident and keeping the resident away from other resident ' s rooms. CNA 4 stated the facility assigned a sitter to the resident that morning (04/13/2022) while the surveyor was in the facility. CNA 4 stated Resident 8 liked to eat other resident ' s food and stated eating other resident ' s food placed Resident 8 at risk for eating something harmful. CNA 4 confirmed the resident was left unattended for "5-10 minutes" and stated she would "go in and out" to check on the resident. CNA 4 stated the patio fence could be hopped over by anyone if they really wanted to get away "even I can hop it". During a concurrent interview and record review on 04/13/2022 at 1:00 PM, the DON reviewed Resident 8 ' s care plan and confirmed the care plan had not been updated since 01/31/2022. The DON stated Resident 8 ' s care plan should have been updated after every wandering incident. The DON reviewed Resident 9 ' s care plan and confirmed the care plan had not been updated since 03/22/2022. The DON stated Resident 9 ' s care plan should have been updated after each wandering incident. The DON stated Resident 8 and Resident 9 ' s care plans needed to be specific and individualized especially since the residents had episodes of going into other resident ' s rooms. The DON stated on 04/07/2022 resident 8 entered Resident 7 ' s room and Resident 7 informed the facility Resident 8 threatened to kill Resident 7. The DON stated Resident 8 should not be left unattended because the resident would go into another resident ' s room or try to elope from the patio. The DON stated, "anything can happen in one to two minutes, residents could get hurt". The DON stated the activities in place for resident 8 and Resident 9 were not effective, and the facility	F 744		

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F 744	Continued From page 15 could only provide a sitter. The DON stated Resident 8 had a sitter assigned on 04/13/2022 because the surveyor was in the facility. The DON then stated Resident 8 had been on one-to-one supervision since an allegation was received against Resident 8 on 04/07/2022. During an observation on 04/13/2022 at 3:10 PM, Resident 8 was observed in without a one-to-one sitter. CNA 4 was observed walking from south unit to the north unit nursing station. DON asked if 1:1 sitter was in place. DON stated yes, the Resident was to always have a sitter with him. DON confirmed sitter was not in resident ' s room and stated, "the next shift sitter is probably running late". A review of the facility ' s policy titled "Dementia-Clinical Protocol" dated November 2018, indicated "For the individual with confirmed dementia, the IDT will identify a resident-centered care plan to maximize remaining function and quality of life". A review of the facility ' s policy titled ' Wandering and Elopements" dated March 2019, indicated "If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety". A review of the facility ' s policy titled "Care Plans, Comprehensive Person-Centered" dated December 2016, indicated "The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment ". The policy indicated the care plan would "Describe the services that are to be furnished to attain or	F 744		

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F 744	Continued From page 16 maintain the resident's highest practicable physical, mental, and psychosocial well-being; Incorporate identified problem areas; Incorporate risk factors associated with identified problems". The policy indicated "Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan". The policy also indicated "Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. When possible, interventions address the underlying source(s) of the problem area(s), not just addressing only symptoms or triggers".	F 744		