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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS00128013.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: The facility census totaled 50 with 6 residents identified as at risk for wandering and 3 residents included in the sample. Based on record review and interview the facility failed to accurately assess resident #2 when he/she had an elopement/Wander Guard bracelet on during the assessment's observation period. Findings included: - Review of the annual minimum data set (MDS) assessment dated 1/10/18 revealed the resident had a brief interview for mental status (BIMS) score of 4, indicating moderate cognitive impairment. The assessment identified the resident with no wander/elopement alarm (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) on at the time of the assessment, although the resident had a physician order dated 12/6/17 for a Wander Guard and facility staff signed they checked the Wander Guard daily during the observation period. Review of the cognitive loss/dementia care area assessment (CAA) dated 1/10/18 revealed the resident had a short-term memory deficit due to	F 641		

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

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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his/her diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). The resident had problems expressing his/her thoughts due to his/her cognition.

Review of the resident's care plan revealed:

12/6/17 - The resident had a risk for wandering. Staff would know if they saw the resident exit seeking they would offer one-on-one visits. Staff could suggest the resident call and talk to his/her spouse.
The care plan intervention dated 12/6/17 lacked any evidence the resident had a Wander Guard bracelet even though the resident had a physician order with the same date to check the resident's Wander Guard (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) placement daily and every shift.

Further review of the resident's care plan lacked any intervention related to the resident's Wander Guard until the facility placed the following interventions:
4/2/18 - The resident had a risk for wandering Staff would know the resident had attempted to look for an exit door and wore a Wander Guard. If staff saw the resident exit-seeking they would offer to sit and visit with him/her. Staff would suggest that the resident call his/her husband so they could talk.

Review of the resident's December 2017 treatment record (TAR) revealed a treatment dated 12/6/18 for staff to check the resident's Wander Guard placement daily, every shift.
Further review of the resident's January 2018

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F 641	Continued From page 2 TAR revealed staff signed the record daily, which indicated they checked the resident's Wander Guard placement daily, every shift. The record lacked any evidence the resident did not have his/her elopement/Wander Guard during the month of January 2018. During interview with administrative staff A at 12:17 PM on 4/9/18 revealed he/she expected the resident's Wander Guard to be coded as in use on the resident's 1/10/18 MDS assessment, according to the Resident Assessment Instrument (RAI) instruction for section P. Review of the "Resident Assessment Instrument (RAI) Manual" dated 10/2017 revealed Wander/elopement alarms included devices such as bracelets, pins/buttons worn on the resident's clothing, sensors in shoes, or building/unit exit sensors worn by/attached to the resident that activate an alarm and/or alert the staff when the resident neared or exited a specific area or the building. This included devices attached to the resident's assistive device (e.g., walker, wheelchair, cane) or other belongings. Staff would code any type of alarm, audible or inaudible, used during the look-back period in section P. If an alarm met the criteria as a restraint, the facility would code the alarm use. The facility failed to accurately assess resident #2 when he/she had an elopement/Wander Guard bracelet on during the assessment's observation period.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657		

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F 657	Continued From page 3 §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: The facility had a census of 50 residents, with 6 residents identified as at risk for wandering, and 3 of those residents included in the sample. Based on observation, interview, and record review the facility failed to ensure staff revised the care plan to reflect wandering prevention interventions for 1 of 3 residents reviewed. (#2) Findings included: - Review of resident #2's medication	F 657		

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administration record for 12/2017 revealed the resident had a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).

Review of the annual minimum data set (MDS) assessment dated 1/10/18 revealed a brief interview for mental status (BIMS) score of 4, indicating moderate cognitive impairment. The resident had no wander/elopement alarm (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) on at the time of the assessment.

Review of the cognitive loss/dementia care area assessment (CAA) dated 1/10/18 revealed the resident had a short-term memory deficit due to his/her diagnosis of dementia. The resident had problems expressing his/her thoughts due to his/her cognition.

Review of the resident's care plan revealed:

12/6/17 - The resident had a risk for wandering. Staff would know if they saw the resident exit seeking they would offer one-on-one visits. Staff could suggest the resident call and talk to his/her family member.
The care plan intervention dated 12/6/17 lacked any evidence the resident had a Wander Guard bracelet (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) even though the resident had a physician order with the same date to check the resident's Wander Guard placement daily and every shift.

Further review of the resident's care plan lacked any intervention related to the resident's Wander

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Guard until the facility placed the following interventions:
4/2/18 - The resident had a risk for wandering Staff would know the resident had attempted to look for an exit door and wore a Wander Guard. If staff saw the resident exit-seeking they would offer to sit and visit with him/her. Staff would suggest that the resident call his/her family member so they could talk.

Review of the nurse's note dated 12/6/17 at 1:18 PM revealed the resident insisted on leaving the facility through the door located by the Social Worker's office. The writer attempted to redirect the resident by stating it was very cold outdoors and he/she would have a long walk home. The resident stated he/she could make it home. The resident agreed to wait for his/her family member to arrive at the facility. The writer asked nursing to place a Wander Guard on the resident. The note further stated the facility updated the elopement book (a book located throughout the facility with residents who had a wandering risk picture in it) with the resident's information and they updated the resident's care plan.

Review of the nurse's note dated 12/6/17 updated at 5:25 PM revealed facility staff asked the resident if he/she would go eat and the resident declined. The resident stated he/she was going to walk and headed to the door. The resident stated he/she just needed to leave. Staff asked the resident if he/she knew the year and he/she responded he/she was not sure. Staff called the resident's family member and he/she stated he/she would be to the facility in an hour. The resident sat down on the bench outside the social worker's office and nurses station, would not walk, eat or do anything else. The facility placed a

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F 657	Continued From page 6 wander guard on the resident's walker since he/she insisted on going outdoors. Review of the resident's December 2017 treatment record (TAR) revealed a treatment dated 12/6/17 for staff to check the resident's Wander Guard placement daily, every shift. During interview with direct care staff I on 4/5/18 at 5:15 AM revealed he/she knew what care to provide residents by looking at the facility communication book and resident care plans. During interview at 6:21 AM on 4/5/18 with direct care staff K revealed he/she knew what care to provide residents by looking at the resident's care plan. During interview with administrative staff A on 4/9/18 at 8:22 AM revealed he/she expected residents' care plans to be updated when staff placed a Wander Guard on a resident. Review of the facility policy "Hazardous Wandering and Elopement" revealed residents who displayed wandering behavior after admission to the community would be assessed and appropriate interventions would be immediately included in the resident's care plan. The facility failed to update resident #2's care plan when staff placed a Wander Guard on the resident after he/she had exit-seeking behavior.	F 657		
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 -	F 689		

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§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:
The facility had a census of 50 residents, with 6 residents identified as at risk for wandering, and 3 of those residents included in the sample. Based on observation, interview, and record review the facility failed to ensure staff implemented immediate accident hazard prevention interventions, as care planned, when staff discovered cognitively impaired resident #1 did not have on his/her WanderGuard (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) bracelet and the staff did not replace it immediately. Later that morning resident #1 wandered outside of the facility at 4:55 a.m. into a courtyard and the door alarm did not sound due to the lack of his/her WanderGuard. This placed resident #1 at risk for accident hazards, with a potential for a negative outcome.

Findings included:

- Review of the 2/21/18 history and physical for resident #1 revealed the following diagnoses: dementia (progressive mental disorder characterized by failing memory, confusion), physical debility, difficulty sleeping, and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) with anxiety (mental or emotional reaction characterized by apprehension, uncertainty and

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irrational fear).

Review of the 11/16/17 quarterly minimum data set (MDS) revealed a brief interview for mental status (BIMS) score of 7, indicating severe cognitive impairment. The resident did not have wandering behaviors and required extensive assistance of one staff with bed mobility, transfers, walk in the room, locomotion on the unit, and dressing; and required supervision of one staff with walk in the corridor and locomotion off the unit. The resident was not steady and only able to stabilize with staff assistance with balance during transitions and walking, had impairment to one side of his/her lower extremity in functional range of motion, and used a walker for mobility. The staff used a motion sensor alarm and a wander/elopement alarm daily on the resident.

Review of the 2/12/18 annual MDS revealed a BIMS score of 4, indicating severe cognitive impairment. The resident did not have wandering behaviors and required the same assistance level as the 11/16/18 assessment with the exception of the resident required supervision of one staff with walk in the room and the corridor and locomotion on the unit. The resident had no change in balance during transitions and walking and continued with the same functional range of motion and mobility device. The staff used a motion sensor alarm and a wander/elopement alarm daily on the resident.

Review of the 2/12/18 Cognitive Loss/Dementia Care Area Assessment (CAA) revealed the resident had short-term memory loss due to his/her diagnosis of dementia and his/her BIMS score indicated severe cognitive deficit. The resident continued to exhibit confusion and was

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not always oriented to time and place. The resident exhibited alterations in his/her thought process and was not able to verbalize his/her thoughts appropriately which was also related to his/her dementia progression.

Review of the 2/12/18 Falls CAA revealed the resident required extensive assistance with all transfers and ambulation. The resident had a history of a fall with hip fracture last year but seemed to have fully recovered. The resident did have a change in his/her gait pattern since then but could walk with standby to limited assistance from staff. The resident had no falls since his/her previous assessment, and at times self-transferred due to his/her dementia and did not remember it was not safe for him/her to do so. The staff placed a motion sensor in his/her room and the staff were notified via pager if the resident got up by him/herself. The resident was administered Celexa (antidepressant medication) routinely in January due to his/her increased signs of anxiety such as ruminating on schedules, activities, and teaching classes. The resident could not be redirected at times and was diagnosed with adjustment disorder with anxiety.

Review of Wandering Screening assessments revealed the following (a score of 11 or above indicated high risk to wander):
6/7/17: score of 13, high risk to wander
11/13/17: score of 12, high risk to wander
2/27/18: score of 16, high risk to wander

Review of the care plan revealed the following interventions:
3/14/17: The resident was at risk for wandering which would be discussed at weekly risk meetings and he/she now had a WanderGuard

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(bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) on his/her walker--updated on 3/26/18 to include the wrist and not the walker.
3/14/17: The resident had trouble remembering the time and might become anxious if he/she thought he/she forgot something.
6/8/17: The staff check on the resident often throughout the night to ensure the resident was not up attempting to do unsafe things.
6/8/17: The resident had unusual sleeping patters and had so for years. The resident woke up around 3:30- 4:00 a.m. and sometimes liked to get ready for his/her day. The staff were to help the resident get dressed if that was the case. The resident might choose to sit in his/her recliner or come out to sit in the living room to be in a public place. The resident could make this choice..
3/18/18: The staff escorted the resident to the place he/she felt he/she needed to be (if in the building) and allowed the resident to visually comprehend he/she should not be at that place currently, if the resident felt as if he/she needed to be someplace and could not understand.
2/16/18: Staff to escort the resident to attend events outside of the facility unit last and allowed the resident to be the first one to be brought back because the resident was at risk for wandering aimlessly.

Review of the physician's orders signed 3/6/18 revealed the resident had a WanderGuard to his/her walker, check daily and change every 90 days.

Review of the nurse's note dated 3/25/18 at 7:05 AM revealed at approximately 5:00 a.m. the resident exited through the dining room courtyard door and went over to the other unit courtyard

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door and staff let the resident back into the facility. The other door alarmed at that time. The resident stated he/she saw the fire pit (fireplace) and wanted to go there. The staff walked the resident back through the hallways to his/her room and assisted the resident to sit in his/her recliner. The staff found the alarm on the dining room door to the courtyard was not working. Staff called security and he/she attempted to reset the alarm but could not get it to work. The security staff stated he/she would put in a work order. The resident had no injury and remained at his/her baseline for confusion and disorientation to time/place. Staff also noted the WanderGuard was not on the resident, not known if he/she got it off in some way as 1st shift nurse reported it was on for day shift on Saturday. Staff obtained a new WanderGuard and placed it on the resident's right wrist and put it on the treatment administration record (TAR). All staff made aware of dining room courtyard door alarm not working at the time.

Review of the nurse's note dated 3/25/18 at 7:52 a.m. revealed staff applied a WanderGuard to the resident's right wrist.

Review of the signed and notarized witness statement by direct care staff C dated 3/30/18 revealed around 4:50 a.m. on 3/25/18 his/her pager went off regarding the door near the fireplace in the unit. As staff C went to investigate the door, he/she heard knocking from the outside patio area and saw resident #1 outside with his/her walker. Staff C opened the door and let the resident inside. Resident #1 did not know what he/she was supposed to be doing. Staff C assisted the resident back to his/her unit and room. The resident was not cold to the touch and did not complain of cold. Staff C discovered the

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dining room door alarm in the long-term care was not working and the alarm was not set to night mode (red light- indicated night mode where the doors remain locked).

Review of the signed and notarized witness statement by direct care staff D dated 3/30/18 revealed at approximately 4:50 a.m. on 3/25/18 he/she received an alarm on his/her pager for the door near the unit by the fireplace. Staff D went to the door and saw resident #1 trying to enter the door. Staff D asked the resident how he/she got to the door and resident #1 said he/she came to see the fireplace. The resident was cool to touch to the hands and face, but not cold. Direct care staff C escorted the resident back to his/her unit. Staff D checked the doors and noted only the dining room door alarm from the long-term care unit that leads to the courtyard was not working, as it was the only one with a green light (day mode- doors are not locked but still have a WanderGuard alarm).

Review of the signed and notarized witness statement from licensed nursing staff E dated 3/30/18 revealed at approximately 4:30 a.m. on 3/25/18 an alarm activated for the other unit patio. Direct care staff C walked up to the door and voiced it was resident #1 standing outside with a walker. The staff assisted the resident inside the unit and the resident smiled and stated, "coming to see the fire." The resident voiced no complaints. The dining room door to the patio opening only made a few beeps, but did not trigger the alarm. The resident had warm skin and did not voice feeling cold. The only door reported as green lit and not red on the activation panel was the long-term care dining room patio door.

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WICHITA PRESBYTERIAN MANOR	4700 W 13TH STREET NORTH WICHITA, KS 67212

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Review of the signed and notarized witness statements from licensed nursing staff F dated 3/29/18 revealed one of the staff from the other unit (unnamed) informed him/her resident #1 had gone through the courtyard to the other unit door. The unnamed staff stated resident #1 said he/she saw the fire pit and wanted to go over there. On walking and checking out the other doors to the courtyard, staff found the dining room door was the only door not set where the alarm was working. The light was green instead of red. The staff related the resident's skin was warm and that his/her time outside was probably 5-7 minutes.

Observation on 4/5/18 at 6:00 a.m. revealed the courtyard was enclosed with even ground, well-maintained sidewalks that were winding, patio furniture on the patio in three different areas, and a clean and neat lawn with landscaping bushes present. The pathway between the dining room doors from long-term care unit and the doors across the courtyard near the fireplace by the therapy side was clear and direct.

Observation on 4/5/18 at 4:50 a.m. revealed all doors in the facility were coded red (night mode) and only one resident was up and dressed in the facility at the time, resident #1. He/she sat in the commons television area across from the nurse's station on the long-term care side of the facility and watched television. The resident was fully dressed with shoes on. The resident had a WanderGuard on his/her right wrist.

Interview with direct care staff I on 4/5/18 at 5:15 a.m. revealed he/she kept an extra eye on

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residents with a risk for wandering. Staff I check on those residents at least once an hour to about every half hour. If he/she saw a resident wandering, staff I guided them in the right direction. Staff I said resident #1 liked to get dressed at 2:00 a.m. and went to bed around 9:30 p.m. Staff I said the staff checked on each WanderGuard placement at the beginning of each shift. Staff I used a handheld device to test if the WanderGuard bracelet worked and staff went around to check doors hourly-to see if they were red lit and reported to security if they were not.

Interview with licensed nursing staff H on 4/5/18 at 5:04 a.m. revealed he/she walked the hallways and checked the doors several times at night. Staff H stated he/she checked to ensure doors were red lit (in night mode). Staff H stated if he/she found a door not red lit (in night mode) he/she would enter a code to turn it back into night mode. Staff H stated the doors were set to switch automatically to night mode, but on 3/25/18 it malfunctioned. Staff H stated the staff were not checking all doors to ensure of no glitches in the system. Staff H said the resident was up sometimes late at night and tended to get up early. The resident tended to think when he/she got up early, he/she needed to get to church. Staff H stated the resident had never got to the doors on his/her shift when he/she worked. Staff H said if a door alarm went off the staff respond to the door by running to the door and starting a head count and bed check of residents. Staff H stated the Wander guard checks were on treatment administration records (TAR) and the TAR alerted the staff about the WanderGuard and if there were any concerns.

Interview with licensed nursing staff M on 4/5/18

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at 10:04 a.m. revealed the resident got very confused at times, especially early in the morning and would think he/she needed to go to school. Staff M stated the staff visualized the resident a lot during his/her shift, due to the resident's wandering. Staff M stated the resident had increased in his/her wandering and wore a WanderGuard on his/her right wrist. Staff M stated he/she replaced the WanderGuard on 3/25/18 when he/she found the resident did not have one on. Staff M stated before 3/21/18 the WanderGuard had been on the resident's walker. Staff M stated the staff never found the WanderGuard the resident removed on 3/25/18 and he/she checked the WanderGuard placement and functionality at the beginning of each shift. Staff M worked 6:00 a.m. - 2:00 p.m. on 3/24/18 and stated the WanderGuard was on the resident's right wrist on that shift. Staff M reported the resident cut his/her WanderGuard off and the staff moved the WanderGuard to his/her walker after that.

Interview with licensed nursing staff B on 4/5/18 at 12:52 p.m. revealed he/she worked the 2:00 p.m - 10:00 p.m. shift on the night of 3/24/18-3/25/18. Staff B reported the resident went to bed at his/her normal time and did not exhibit wandering behavior on his/her shift. Staff B reported he/she did not remember the courtyard being used, ever. Staff B stated he/she did not work in the long-term care unit a lot and stated he/she looked on the resident's wrist and walker and did not find the WanderGuard. Staff M stated he/she passed on that information to the next shift at report and stated he/she checked for the WanderGuard around 3:00 p.m. Staff M stated he/she kept the resident in visual range during his/her shift to ensure the resident did not

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go outside and staff M did frequent rounds.

Interview with licensed nursing staff F on 4/5/18 at 1:07 p.m. revealed he/she was the night shift nurse (10:00 p.m.- 6:00 a.m.) on the night of 3/24/18-3/25/18. Staff F stated he/she looked in on the resident every time he/she went past the resident's room and stated the resident just wanted to sleep in his/her recliner. Staff F stated the last time he/she walked past resident #1's room the direct care staff was assisting the resident up to the bathroom around 4:30 a.m.-4:45 a.m. Staff F stated he/she did not check the WanderGuard placement on the resident at the beginning of his/her shift. Staff F stated the previous nurse had reported the lack of a WanderGuard on the resident in report to him/her. Staff F reported the resident will get up at times at midnight and think it is time to get up, but not that night. The resident slept through the night. Staff F stated after the other unit staff informed him/her of the resident walking through the courtyard doors, he/she noticed the dining room door was not functioning and called security right away. Staff F stated the security staff G could not reset the door and therefore staff placed a table in front of the dining room door and let all staff know to watch the door and residents at risk for wandering.

Interview with administrative nursing staff A on 4/5/18 at 6:50 a.m. revealed resident #1 left out the courtyard doors and went to the other unit doors, but could not get it opened. Staff A stated he/she reviewed the camera footage from security cameras and saw the resident left through the long-term care dining room doors around 4:55 a.m. and at 4:57 a.m. staff let the resident in through the other unit doors-a matter

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of 2 minutes. The resident had on long sleeve shirt, slacks, shoes and was fully dressed for the day and used his/her walker. Staff A stated the resident was often dressed for the day in the night. Staff A stated two of the courtyard doors were both automatic to switch from day (green light) to night mode (red light). Staff A stated the facility now kept the courtyard doors on night mode at all times. Staff A stated when the door was on night mode it would alarm if it was opened and it if was on day mode it would not sound unless someone got to close with a WanderGuard bracelet. Staff A stated the resident had just had his/her WanderGuard changed from being on his/her walker to his/her wrist days prior to the incident. Staff A stated the night nurses check the WanderGuard system nightly. Staff A stated the staff did notice the resident did not have on his/her WanderGuard bracelet and the staff did not put in an appropriate intervention in place and that was how the resident got out.

Interview with administrative nursing staff A on 4/9/18 at 8:22 a.m. revealed the WanderGuard system was moved from the resident's walker to his/her wrist because the system worked best if the WanderGuard was on the person. There had been an email sent out and stated metal from the walker could interfere with the function of the WanderGuard. Staff A stated he/she expected the care plan to be updated before 3/26/18 and he/she did not know why the care plan was not updated with the WanderGuard being moved to his/her wrist. Staff A stated he/she did education with the staff nurses to ensure the staff put the WanderGuard on the TAR as being on the right wrist and charted there. Staff A expected staff to immediately put one on him/her or call the DON and ask why if staff found a resident without a

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F 689	Continued From page 18 WanderGuard who was supposed to have one. Review of the facility policy titled, Hazardous Wandering and Elopement (unwitnessed exit) revised 09/2016 revealed the facility would exercise reasonable care to prevent injuries and ensure a secure environment for residents. The policy defined elopement as an unassisted, unsupervised, unscheduled departure from the facility by an individual. Elopers could be differentiated from wanderers by their purposeful, overt, and often repeated, attempts to leave. Resident behavior may be characterized by: low risk, at risk to wander, & high risk to wander. Definition of wanderer: Aimless or purposeful motor activity that causes a social problem such as getting lost, leaving a safe environment, or intruding in inappropriate places. To minimize risks associated with wandering is to identify wandering-prone individuals on admission. Residents with potential to unwitnessed exit included those with a prior history of wandering, those with obvious impaired decision-making ability or impaired cognition are oblivious to their own safety needs and who are mobile (walking or using a wheelchair or similar assistive device). Staff, especially the primary caregivers, would be notified of residents who would likely to attempt to leave or to get lost within the facility. Residents identified as at risk for an unwitnessed exit would wear an identification accessory and/or monitor at all times. Doors exiting the facility would be alarmed at all times, unless visually monitored. At the beginning of each shift, the charge nurse would ensure residents assessed to be at risk for an unwitnessed exit were located and the door alarm system was visually monitored or enabled. All alert band batteries would be checked daily by the nursing staff to ensure they functioned	F 689		

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F 689	Continued From page 19 properly. The policy included suggested interventions for wandering behavior which included to follow the plan of care interventions for wandering behavior. The facility to ensure staff implemented hazard prevention interventions as care planned for resident #1, who did not have on his/her WanderGuard bracelet and later walked outside of the facility into a courtyard without staff supervision.	F 689		