AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

August 29, 2023

Ms. Tabitha Davis-Barron, Administrator
Bennington Health & Rehab
2 Blackberry Lane
Bennington, VT 05201-2300

Dear Ms. Davis-Barron:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **July 28, 2023.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

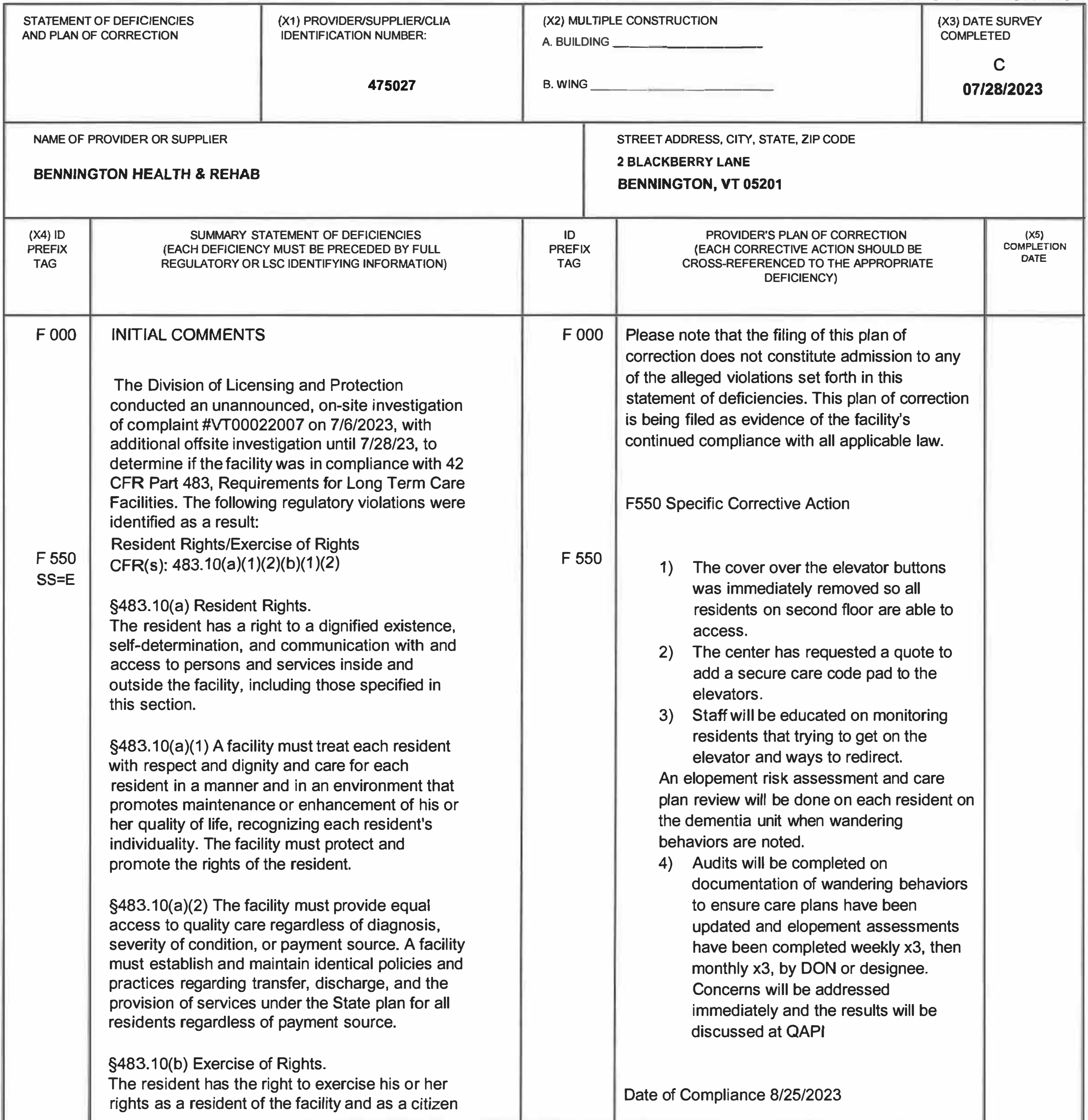
Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PRINTED: 08/14/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475027	A. BUILDING ______ B. WING ______	C 07/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNINGTON HEALTH & REHAB	2 BLACKBERRY LANE BENNINGTON, VT 05201

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F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, on-site investigation of complaint #VT00022007 on 7/6/2023, with additional offsite investigation until 7/28/23, to determine if the facility was in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following regulatory violations were identified as a result:	F 000	Please note that the filing of this plan of correction does not constitute admission to any of the alleged violations set forth in this statement of deficiencies. This plan of correction is being filed as evidence of the facility's continued compliance with all applicable law. F550 Specific Corrective Action	
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen	F 550	1) The cover over the elevator buttons was immediately removed so all residents on second floor are able to access. 2) The center has requested a quote to add a secure care code pad to the elevators. 3) Staff will be educated on monitoring residents that trying to get on the elevator and ways to redirect. An elopement risk assessment and care plan review will be done on each resident on the dementia unit when wandering behaviors are noted. 4) Audits will be completed on documentation of wandering behaviors to ensure care plans have been updated and elopement assessments have been completed weekly x3, then monthly x3, by DON or designee. Concerns will be addressed immediately and the results will be discussed at QAPI Date of Compliance 8/25/2023	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature] LNHA	CED	8/21/23

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 550	Continued From page 1 or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Per observations, interview, and record review the facility failed to develop and implement policies and procedures related to secured/locked areas, including criteria for placement and ongoing assessment to assure that the resident meets the criteria. Findings include: Per review of the facility Detailed Census Report there are 20 residents who currently reside on the second floor of the facility (2 South). During unit observations on 7/6/2023 at 12:15 PM a metal cover with two small holes was noted to be fastened over the elevator buttons preventing the ability to push the buttons that call for the elevator. Per interview on 7/6/2023 at 12:20 PM with the Licensed Practical Nurse (LPN) there are 20 residents to care for on the unit. The residents with dementia were moved from the third floor down to the second floor a few months ago. There are several residents who wander around getting into others rooms and try to get in the	F 550	**Tag F 550 POC accepted on 8/29/23 by S. Freeman/P. Cota**	

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F 550	Continued From page 2 elevator to leave. In order to access the elevator a pen or pencil must be inserted into one of the holes in the cover that hides the buttons. This is because some of the "residents try to get out." Per interview with the Center Executive Director (CED) and the Director of Nursing (DON) on 7/7/2023 at approximately 4:30 PM the residents who reside on the 2nd floor have dementia and wander the unit, at times they attemt to get on the elevator and leave. The elevator buttons are covered to prevent residents who wander from accessing the buttons, getting on the elevator, and getting outside the building unsupervised. When asked if the facility had policies and procedures related to secured/locked units the CED and DON both confirmed that none had been developed or implemented for this unit.	F 550		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584	F584 Specific Corrective Action 1)An A/c unit was brought to resident #7's room he told maintenance he did not want the a/c. Resident #9 was offered an A/c as well. Resident #8 had a facility fan placed in his room. 2)All resident rooms had fans placed, a/c units are available upon request. 3)Temperatures to be taken twice daily M F, once in AM and once in PM, in all occupied resident rooms and public areas when heat advisory is issued. If higher than 81 degrees, administrator to be notified immediately and action will be taken. Temperature preference will be added to Partner Program rounding questionnaire to ensure each resident is comfortable in their home. 4) Results of the Partner Program surveys and the temperature logs will be reviewed regularly and Audits completed weekly x3, then monthly x3 by Administrator or designee, results to be discussed at QAPI Date of Compliance 8/25/2023	

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F 584	Continued From page 3 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Per observation and interview the facility failed to ensure the temperature in the halls and resident rooms remained at a comfortable temperature for residents and staff, by not providing air conditioners and fans in extreme heat. During an interview with Resident #7 on 7/6/23 at 2:30 PM s/he was observed laying in her/his bed with just a gown folded up covering her/his brief area. The resident stated that it was very hot in her/his room. S/he said that it was cooler than it had been the day before, but it was still too hot. When asked if s/he had told staff that it was hot s/he said "yes, they said that there is nothing they can do about it."	F 584	**Tag F 584 POC accepted on 8/29/23 by S. Freeman/P. Cota**	

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F 584	Continued From page 4 Per interview with maintenance staff on 7/6/2023 at 2:40 PM s/he stated that all the air conditioners and fans available in the building were already in use by other residents. S/he also stated that getting an air conditioner or fan was based on need, if the resident was having problems with their breathing, they would get one first. Per interview with the Unit Manager (UM) on 7/6/2023 at 2:45 PM the heating and cooling vents in the hall do not always blow cool air from them and it gets extremely warm on hot days especially if a resident prefers to keep their door shut. Residents and family members have complained, and some have purchased their own fans because it is too hot. The UM confirmed that it was hot in many rooms on the unit especially the 3 South side. On 7/7/2023 at 1:30 PM Resident #9 was observed in their room working with therapy. The resident reported that it was extremely warm in the room, and s/he was very uncomfortable. Using an infrared thermometer this surveyor obtained surface temperatures in several areas in the room. When reading the temperature of the surface of the bed the reading was noted as 82.5 degrees. During an interview with Resident #8 and her/his family members on 7/7/2023 at approximately 3:30 PM Resident #8 stated it was hot in her/his room. The family was observed assembling a fan that they had purchased for the resident. Using an infrared thermometer this surveyor obtained the surface temperature on the wall furthest from the window and obtained a reading of 86.5 degrees.	F 584		

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F 584	Continued From page 5 During an interview with the Director of Nursing on 7/6/2023 at 4:45 PM it was revealed that the facility does have fans and air conditioners in storage, but they have not been able to access them. The decision of who does and doesn't get an air conditioner is not made by nursing. The DON confirmed that many rooms in the building too hot, and the residents and staff are not comfortable.	F 584		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: The facility failed to provide an ongoing program to support residents who reside on the 2 South unit in their choice of activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Per Interview with the Center Executive Director on 7/6/2023 at 11:30 AM there have been several altercations between residents on the 2 South unit. A facility review of the incidents revealed that	F 679	F679 Specific Corrective Action 1)Activities and nursing staff started to use the "day room" to engage residents in activities throughout the day on the second floor. 2) A certified therapeutic recreational specialist will be starting on 8/28/23 and will be developing a calendar specified for the second floor. 3)Education will be done with direct care staff and the recreation team on dementia specific activities. 4) Activity sign in sheet will be audited for participation of second floor weekly x3 and then monthly x3 by Administrator or designee. Results will be discussed at QAPI Date of Compliance 8/25/2023 **Tag F 679 POC accepted on 8/29/23 by S. Freeman/P. Cota**	

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F 679	Continued From page 6 the residents are bored. The facility plans to implement activities appropriate for residents with dementia, however, there are currently no activities offered for the residents who decline participation in the third-floor activities. Per observations conducted on 7/6/2023 between 12:00 - 12:30 PM on the 2 South unit there were three residents in wheelchairs self-propelling throughout the unit. There were 4 residents finishing lunch in the dining room.,one Licensed Practical Nurse (LPN) and two Licensed Nursing Assistants on duty. Per interview on 7/6/23 at 12:20 PM with a Licensed Practical Nurse (LPN) who was working on the 2 South unit there have been an increase in resident-to-resident altercations and other behaviors on the unit. The LPN stated that there is not enough staff to supervise the residents who wander and there are no activities on the unit. S/he stated that s/he feels that the residents "are bored.'" The LPN stated that activity staff come to the second floor and invite some of the residents to the activities on the third floor, but most refuse and then that is it, they stay on the second floor with nothing to do. There is no opportunity for the residents who refuse to participate to attend after the initial offer as they are unable to access the elevator and go to the 3rd floor. Per observations made between 7/6 and 7/7/23 the 2 South elevator access buttons had a metal plate over them. Staff insert a pen or pencil into a small hole in the plate in order to push the button and call for the elevator. This prohibits the residents who reside on 2 South from leaving the unit without staff assistance.	F 679		

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F 679	Continued From page 7 During an interview with the Therapeutic Recreation Director (TRD) on 7/7/2023 at 4:00 PM the Participation Reports were reviewed. The TRD stated that each resident on 2 South gets the "Chronicles" delivered to their room. During this delivery activity staff are to check in and see how the resident is doing and if they need anything. This is coded on the Participation Report as active participation with "Chronicles". The TRD confirmed that there have been no scheduled activities on the second floor, and most of the second floor residents decline participation in the third floor activities.	F 679		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.	F 725	F725 Specific Corrective Action 1)Medication orders were reviewed for Residents #2, #3, #4, #5, and #6 and administration times adjusted to provide efficiency in medication delivery by nursing staff to meet the needs of the residents and medication administration times 2) A review of all residents Medication orders is being completed to meet the needs of the residents and the medication times staggered to meet the needs of the nursing staff per the provider's orders. The center will work with the Medical Director and the Pharmacy Consultants to review current medications and reduce/consolidate where possible. To ensure adequate supervision of 2S residents an activities director and aide as well as 6 additional nurses were hired 3) Education to licensed nursing staff will be completed on the facility policy titled HA2: Medication Administration-General Guidelines Section B. 10) "Medications are administered within 60 minutes of scheduled time". 4)DON/Designee will randomly check licensed nurses during medication passes to audit medication administration times are within the 60-minute variance. Any inconsistencies will be addressed immediately by DON/designee. Audits will be done daily M-F x 3 weeks, then weekly x3months A member of the management team will complete safety rounds M-F on all units x3 weeks, then once weekly x3 months. To ensure safe staffing levels are in place. Any inconsistencies will be addressed immediately by DON/designee Date of Compliance 8/25/2023	

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F 725	Continued From page 8 §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Per observation, interview, and record review the facility failed to ensure that there was sufficient staff to administer medications per physicians' orders and facility policy for 5 of 5 residents in the sample (Residents #2, #3, #4, #5, and #6), and failed to provide adequate supervision to maintain the safety of the residents on the 2 South unit. 1. Per interview with the 3rd floor Unit Manager (UM) on 7/6/2023 at 1:15 PM the 3 North nurses have been responsible for providing "primary nursing" attending to all resident care needs such as providing or assisting with personal care, medication administration, and performing treatments for up to 9 residents. The unit has been staffed with no Licensed Nurse Assistant (LNA). Per interview on 7/6/2023 at 1:30 PM the Registered Nurse (RN) on the 3 North unit s/he has been scheduled to work on the 3 North unit alone, providing personal care, medications, and treatments for 8 to 9 residents. S/he thinks that the expectation is that the Licensed Nursing Assistants (LNAs) from 3 South will come to help when needed, but that does not usually happen because they are busy caring for the 20 residents on 3 South. The RN stated that s/he must prioritize and take care of the residents' personal care needs the best s/he can. Medications and treatments are often late and there is no time to document in the medical record because s/he is	F 725	**Tag F 725 POC accepted on 8/29/23 by S. Freeman/P. Cota**	

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F 725	Continued From page 9	F 725		

responsible for providing all care and nursing duties.

Review of the 7/6/2023 facility census there were currently 9 residents residing on the 3 North unit. The LNA assignment sheets reflect 8 residents who require 1 assist with activities of daily living (dressing, grooming, bathing, and toileting), 4 residents who require 1 staff assist for transfers, 1 resident who requires two extensive assist, and 1 who requires two staff assist with a stand lift for transfers. Facility staffing sheets for 6/1 - 7/7/23 (37 days) reveal that on 26 days there was one nurse and no LNAs scheduled on 2 North for the 7:00 AM - 3:00 PM shifts and 15 evenings where there was one nurse with no LNAs scheduled for the 3:00 PM - 11:00 PM shifts. There were eight 3:00 PM - 11:00 PM shifts with one nurse scheduled to work both 3 North and 3 South units.

Per review of five residents' Medication Administration Audit Reports for 6/1 - 7/7/2023 revealed the following medication administration discrepancies:

Resident #2 received 956 medications over 60 minutes after the ordered administration time.
Resident #3 received 199 medications over 60 minutes after the ordered administration time.
Resident #4 received 95 medications over 60 minutes after the ordered administration time.
Resident #5 received 280 medications over 60 minutes after the ordered administration time.
Resident #6 received 54 medications over 60 minutes after the ordered administration time.

Review of the facility policy titled HA2: Medication Administration-General Guidelines revealed in Section B. 10) "Medications are administered

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F 725	Continued From page 10	F 725		

within 60 minutes of scheduled time".

During an interview on 7/7/23 at 4:00 PM the RN confirmed that medications are not administered timely due to a lack of staff on the unit.

Per interview on 7/7/2023 at 4:45 PM with the Director of Nursing (DON) staffing levels are established by calculating the Per Patient Day (PPD, a measurement used to compare total number of direct care hours to total number of patients served), not based the needs and acuity of the specific residents who reside in the facility. There is a resident on 2 South who requires a staff member to be with them at all times, this staff member is included in the PPD calculation. The DON confirmed that there had been only one nurse scheduled to provide care, medications, and treatments for the residents on the 3 North unit. S/he also confirmed that the five residents in the sample did not receive their medications within the established time frame and it is the facility policy to do so.

2. During observations of the 2 South unit on 7/6/2023 at 12:10 PM there was one Licensed Practical Nurse (LPN) who was currently passing medications to the residents and two Licensed Nursing Assistants who were in resident rooms providing care.

Per interview with the Licensed Practical Nurse (LPN) assigned to the 2 South unit there are 20 residents who require assistance with care, medication administration, and treatments. There are several residents with behaviors and who wander into other's rooms. There has been an increase in resident-to-resident altercations because staff get busy and there is no one

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F 725	Continued From page 11 watching them and nothing for them to do. S/he tries to "stay up on PRNs" (as needed) medications to help decrease behaviors but s/he "can't always do it" because it gets too busy. Per review of the facility 7/6/2023 census there are currently 20 residents who reside on 2 South. Licensed Nurse Assistants (LNA) team assignment sheets provided by the Director of Nursing (DON) reflect that 10 of the 20 residents require 2 staff assist using a Hoyer (mechanical) lift for all transfers. 12 residents require one staff assist with care, 3 require 1-2 assist with care depending on behaviors, and 3 require 2 staff assist with care. During unit observations on 7/7/2023 at between 6:00 PM and 6:30 PM one resident was wandering around with a cell phone asking for help and where to go. This resident appeared anxious and was repeating the words come help me honey. Another resident who is care planned for 1 assist/supervision with a walker and gait belt for transfers/ambulating was ambulating unassisted toward the LPN with no gait belt or walker. Another resident who is being titrated off 1:1 as of 7/6/2023 was ambulating in and out of resident rooms unsupervised, and three residents were self-propelling in the hall in their wheelchairs. Per interview on 7/7/2023 at 6:00 PM with the LPN on the 2 South unit the residents who reside there have dementia and require a lot of care. Many residents wander around the unit and go in and out of other's rooms. There are two LNAs assigned to the unit and between the three staff they cannot provide the supervision needed for the residents. The LPN stated that there have	F 725		

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F 725	Continued From page 12 been several resident-to-resident altercations and the residents are under supervised and bored. Per interview on 7/7/2023 at 6:15 PM with a Licensed Nurse Assistant on the 2 South unit there is not enough staff to "keep an eye on" the residents. S/he stated that there are so many residents who require 2 staff assist with care and transfers with a Hoyer lift, when staff are in resident's rooms providing care there is no one in the halls watching the residents who wander around. The LNA stated "there is just no way that we can be providing care and watch the residents at the same time." Per interview on 7/7/2023 at 4:45 PM with the Director of Nursing there are a lot of residents on the 2 South unit who have behaviors and require supervision. The DNS confirmed that at times there is not enough staff to maintain supervision of the residents.	F 725		
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, interview, and record review the facility failed to implement individualized interventions as well as revise the care plan accordingly, to address the resident's dementia care needs related to wandering, elopement risks, and person-centered activities for 1 resident in the applicable sample (Resident	F 744	F744 Specific Corrective Action 1)Resident #1 is attending activities on third floor if she chooses with the supervision of the activities staff. Care plan updated with interventions for exit seeking behaviors and redirection. 2)Care plan review of residents on the dementia unit will be reviewed for proper interventions and person centered activities. A certified therapeutic recreational specialist will be starting in 8/28/23 and will be developing a calendar specified for the second floor. Requisitions to add 1 full-time recreation staff has been opened to increase the recreation team. 3)Education will be done with direct care staff and the recreation team on dementia specific activities. The activities staff will develop activities appropriate for the dementia unit that focuses on the needs of the residents with dementia. NHA contacting QIO for dementia specific training material. 4)Audits of appropriate person centered activities for the dementia unit will be completed weekly x3, then monthly x3 by Administrator or designee. Results will be discussed at QAPI. Date of Compliance 8/25/2023.	

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F 744	Continued From page 13 #1). Findings include: Per record review Resident #1 was admitted to the facility with diagnoses that include frontotemporal dementia and anxiety disorder. S/he was transferred from the 3rd floor to the 2 South unit on 3/1/2023. An interview with a Registered Nurse (RN) conducted on 7/6/23 at 4:45 PM revealed that Resident #1 had recently cut their Wander Guard off on two occasions. On the second occasion s/he was noted to have a pair of scissors in her/his room. Upon investigation the facility concluded that s/he had obtained the scissors while participating in an activity on the third floor. It was determined that s/he would no longer be able to attend activities on the third floor due to the inability to supervise her/him while s/he is there. The RN stated that the resident continues to try to gain access to the elevator, and that there are no activities to engage the residents on the 2 South unit. A progress note dated 6/11/23 reflects that Resident #1 requires a Wander Guard/Wander Elopement Device (a wander management system that alarms when a resident attempts to exit a certain area) due to poor safety awareness. A progress note dated 6/12/2023 reflects that the resident was given new bands for her/his Wander Guard, and an hour later s/he gave them to the nurse stating, "I don't want to wear these stupid things." The nurse looked in her/his room and found and removed a pair of scissors. New bands were placed on the resident's left arm, as s/he did not want them on her/his ankle. A progress note dated 6/13/23 reflects that the resident removed the Wander Guard to left wrist. Progress notes	F 744	**Tag F 744 POC accepted on 8/29/23 by S. Freeman/P. Cota**	

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F 744	Continued From page 14 written every day from 6/16/23 to 7/2/23 reflect that Resident #1 did not have the Wander Guard on. A progress note dated 6/14/23 reveals that the resident "exhibits wandering daily or almost daily and poses significant risk and/or is intruding on others. Resident is experiencing impulsive behavior... shadowing staff/other patients. Exhibits behavior: hovering Near exits." On 6/20/23 a note written by the Nurse Practitioner (NP) reflects "that nursing reports increased wandering and attention seeking behaviors from resident to include opening closing windows and doors, entering, and exiting patient rooms as well as the kitchen area. When nursing attempts to redirect the resident s/he becomes agitated requiring multiple attempts by multiple people." An elopement evaluation completed on 7/2/23 reflects that the resident has a history of actual elopement or attempted elopement. Review of the resident's care plan reveals that there is no care plan in place that addresses wandering, and elopement risk specifically related to removing the Wander Guard and exit seeking. Nor does the care plan specify interventions for staff to implement to ensure the resident does not exit unsupervised or to manage exit seeking behaviors. A behavior note written on 7/3/2023 states the resident tried to enter the dining room while it was closed. The resident was redirected with a lot of talking and education regarding safety and why it is closed. Resident continues to bang on the door for it to be opened. A behavior note dated 7/5/23 states "resident has been going into other residents' rooms, found [her/him] in the solarium yelling at the window "look at them kids" "come here come here" she was seeing the tv reflection in the window. Resident was also holding onto	F 744		

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F 744	Continued From page 15 resident's wheelchairs not allowing them to go down the hall." Another progress note dated 7/5/23 states "Has not slept all shift/Freq ambulating to nurses' station and in hallway...When ambulating [frequently] going into other residents' rooms/Very difficult to redirect/Insisting [s/he] be allowed in rooms to "see what is going on"/Belligerent and argumentative with attempts to redirect/Trying to push staff so [s/he] could walk around them to get into rooms/Required 1:1 supervision for [approximately] 30min until this behavior subsided..." A progress note dated 7/9/2023 states "Unable to redirect [resident] away from the hall entrance to the kitchen, resident was banging on the door using foul language." A progress note written on 7/7/2023 reveals that the resident was found in another resident's bathroom and resisted redirection. A care plan focus initiated on 6/1/23 reveals that Resident #1 has a history of lack of safety awareness as evidenced by unsafe behaviors due to dementia. The stated goal is the resident will not experience major injury related to unsafe behaviors x 90 days. A care plan initiated on 6/26/2023 indicates that Resident #1 is at risk for being a victim of potential abuse by other dementia residents due to poor safety awareness and doesn't understand personal boundaries and invaded other's personal space. The care plan does not indicate interventions to prevent the resident from entering other resident rooms, and behaviors related to attempting to gain entrance to the dining area and unit kitchenette. There are also no interventions in place to assist staff in effective management of these behaviors. Review of the resident's activity care plan initiated on 8/24/2022 reveals that the resident "exhibits or	F 744		

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F 744	Continued From page 16 is at risk for limited and/or meaningful engagement related to: Indicators of anxious behavior. Cognitive loss/dementia. Ambulates independently. Alert, pleasant. The care plan does not reflect appropriate interventions to ensure that the resident is able to participate in activities that promote their highest practicable well-being or indicate interventions to ensure that the resident is safe attending the activities on the third floor such as supervision. There are no interventions implemented that ensure that the resident is engaged in activities on the 2 South unit. Per interview with the Center Executive Director on 7/6/23 at 12:00 PM the residents on the 2 South unit are bored. There is not enough going on to keep them engaged. There is a plan to increase the amount and improve the content of activities provided on 2 South. However, there is no consistent activity program being offered at this time. Per interview on 6/7/23 at 4:00 PM the Therapeutic Recreation Director (TRD) residents with dementia were moved to the 2 South unit because the facility was planning on implementing an activity program that would better meet their needs. However, the activities program does not have enough staff to implement a program that supports dementia specific activities. The TRD confirmed that Resident #1 used to enjoy activities on the third floor, and s/he is no longer allowed to attend them. The TRD also confirmed that currently there is no activity program in place on the 2 South unit that focuses on the needs of the residents with dementia.	F 744		