STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035121	A. BUILDING _____ B. WING _____	12/06/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BANNER BOSWELL REHABILITATION CENTER	**10601 WEST SANTA FE DRIVE SUN CITY, AZ 85351**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation and policy review, the facility failed to implement their abuse policy regarding reporting and protection for an allegation of abuse involving one of two sampled residents (#72). The deficient practice could result in the potential for abuse to be unreported and ongoing. Findings include: Resident #72 was admitted to the facility on (MONTH) 21, (YEAR) with [DIAGNOSES REDACTED]. Review of a facility report dated (MONTH) 27, (YEAR) revealed that on (MONTH) 23, (YEAR) at approximately 7:30 a.m., the resident's Certified Nursing Assistant (CNA/staff #42) reported to the nurse the resident had a skin tear on the hand that was bleeding. The nurse assessed the injury and noted the resident was bleeding from a foam dressing that was already in place. As the nurse was leaving the room to get supplies, a family member was entering the room. When the nurse returned to the resident's room, she observed the family member screaming at the CNA and taking pictures. The unit manager Registered Nurse (RN/staff #114) was notified and took over the care of the resident. The report included the resident had multiple skin tears and that the family member accused the CNA of abusing the resident. An investigation was initiated. The report did not include measures were implemented to prevent further potential abuse while the investigation was in progress. Further review of the report revealed no evidence the allegation of abuse was reported immediately, but not later than 2 hours after the allegation was made to the administrator, State Survey Agency and adult protective services (APS). The report included the State agency was notified via the after-hours number on (MONTH) 23, (YEAR) at 9:09 p.m. and APS was notified on (MONTH) 27, (YEAR). An interview was conducted with staff #114 on (MONTH) 4, 2019 at 1:57 p.m. Staff #114 stated that regarding the incident that occurred on (MONTH) 23, (YEAR), she thought the family member had retracted the abuse allegation so she did not immediately inform the Director of Nursing (DON/staff #115) and did not notify the administrator (staff #70) and did not suspend staff #42. Staff #114 stated staff #42 continued to provide care to residents and that the residents were not protected from the potential for further abuse. An interview was conducted with the DON (staff #115) on (MONTH) 6, 2019 at 11:15 a.m. Staff #105 stated the administrator, who is the designated facility abuse officer, is to be immediately notified when there is an allegation of abuse. Staff #115 stated the administrator was eventually notified of this incident; however it was much later that day (December 23, (YEAR)). Staff #115 also stated the State Survey Agency and APS were not notified within the required two hour time frame. Staff #115 stated that when there is an allegation of abuse and the perpetrator is staff, the staff is suspended until the investigation is completed for the protection of the residents. Staff #115 further stated staff #42 was not suspended, per policy, and continued to provide resident care. An interview was conducted with the administrator (staff #70) on (MONTH) 6, 2019 at 12:15 p.m. Staff #70 stated staff are to immediately notify her when there is an allegation of abuse. Staff #70 stated that she has to report the abuse allegation to the State Survey Agency and APS within two hours. Regarding the incident that occurred on (MONTH) 23, (YEAR), staff #70 stated staff #114 did not immediately report the abuse allegation and therefore the allegation was not reported to the State Survey Agency and APS within the required time frame. Staff #70 also stated staff #42 was not suspended and was allowed to continue to provide care to residents which was not in compliance with their policy. The facility's policy regarding abuse revised (MONTH) 16, (YEAR), revealed abuse allegations are reported per Federal and State Law. Staff must always report any abuse or suspicion of abuse immediately to the administrator. The policy also revealed the facility will ensure that all alleged violations involving abuse are reported immediately, but not later than 2 hours after the allegation is made to the State Survey Agency and APS. The policy also included it is their policy that the resident(s) will be protected from the alleged offender(s). Staff accused of alleged abuse will be placed on administrative leave pending the results of a thorough investigation.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation and policy review, the facility failed to ensure an allegation of abuse involving one of two sampled residents (#72) was reported to the administrator, State Survey Agency, and adult protective services (APS) within the required timeframe. The deficient practice could result in abuse allegations not being report as required. Findings include: Resident #72 was admitted to the facility on (MONTH) 21, (YEAR) with [DIAGNOSES REDACTED]. Review of a facility report dated (MONTH) 27, (YEAR) revealed that on (MONTH) 23, (YEAR) at approximately 7:30 a.m., the resident's Certified Nursing Assistant (CNA/staff #42) reported to the nurse the resident had a skin tear on the hand that was bleeding. The nurse assessed the injury and noted the resident was bleeding from a foam dressing that was already in place. As the nurse was leaving the room to get supplies, a family member was entering the room. When the nurse returned to the resident's room, she observed the family member screaming at the CNA and taking pictures. The unit manager Registered Nurse (RN/staff #114) was notified and took over the care of the resident. The report included the resident had multiple skin tears and that the family member accused the CNA of abusing the resident. Further review of the report revealed no evidence the allegation of abuse was reported immediately, but not later than 2 hours after the allegation was made to the administrator, State Survey Agency and APS. The report included the State agency was notified via the after-hours number on (MONTH) 23, (YEAR) at 9:09 p.m. and APS was notified on (MONTH) 27, (YEAR). An interview was conducted with staff #114 on (MONTH) 4, 2019 at 1:57 p.m. Staff #114 stated that regarding the incident that occurred on (MONTH) 23, (YEAR), she thought the family member had retracted the abuse allegation so she did not immediately inform the Director of Nursing (DON/staff #115) and did not notify the administrator (staff #70). An interview was conducted with DON (staff #115) on (MONTH) 6, 2019 at 11:15 a.m. Staff #115 stated the administrator, who is the designated facility abuse officer, is to be immediately notified when there is an allegation of abuse. Staff #115 stated the administrator was eventually notified of this incident; however it was much later that day (December 23, (YEAR)). Staff #115 also stated the State Survey Agency and APS were not notified within the required two hour time frame. An interview was conducted with the administrator (staff #70) on (MONTH) 6, 2019 at 12:15 p.m. Staff #70 stated staff are to immediately notify her when there is an allegation of abuse. Staff #70 stated that she has to report the abuse allegation to the State Survey Agency and APS within two hours. Regarding the incident that occurred on (MONTH) 23, (YEAR), staff #70

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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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) stated staff #114 did not immediately report the abuse allegation and therefore the allegation was not reported to the State Survey Agency and APS within the required time frame. The facility's policy regarding abuse revised (MONTH) 16, (YEAR), revealed abuse allegations are reported per Federal and State Law. Staff must always report any abuse or suspicion of abuse immediately to the administrator. The policy also revealed the facility will ensure that all alleged violations involving abuse are reported immediately, but not later than 2 hours after the allegation is made to the State Survey Agency and APS.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation and policy review, the facility failed to ensure action was taken to prevent further abuse from occurring while the investigation was in progress for an allegation of abuse involving one of two sampled residents (#72). The deficient practice could result in residents not being protected from the potential for further abuse. Findings include: Resident #72 was admitted to the facility on (MONTH) 21, (YEAR) with [DIAGNOSES REDACTED]. Review of a facility report dated (MONTH) 27, (YEAR) revealed that on (MONTH) 23, (YEAR) at approximately 7:30 a.m., the resident's Certified Nursing Assistant (CNA/staff #42) reported to the nurse the resident had a skin tear on the hand that was bleeding. The nurse assessed the injury and noted the resident was bleeding from a foam dressing that was already in place. As the nurse was leaving the room to get supplies, a family member was entering the room. When the nurse returned to the resident's room, she observed the family member screaming at the CNA and taking pictures. The unit manager Registered Nurse (RN/staff #114) was notified and took over the care of the resident. The report included the resident had multiple skin tears and that the family member accused the CNA of abusing the resident. An investigation was initiated. However, the report did not include measures were implemented to prevent further potential abuse while the investigation was in progress. An interview was conducted with staff #114 on (MONTH) 4, 2019 at 1:57 p.m. Staff #114 stated that she did not suspend staff #42 and that staff #42 continued to provide care to residents. She stated staff #42 was not suspended until the Director of Nursing (DON) was aware staff #42 was still providing care to resident. Staff #114 stated the residents were not protected from the potential for further abuse. An interview was conducted with the DON (staff #115) on (MONTH) 6, 2019 at 11:15 a.m. Staff #115 stated that when there is an allegation of abuse and the perpetrator is staff, the staff is suspended until the investigation is completed for the protection of the residents. Staff #115 further stated staff #42 was not suspended, per policy, and continued to provide resident care. An interview was conducted with the administrator (staff #70) on (MONTH) 6, 2019 at 12:15 p.m. Staff #70 stated staff #42 was not suspended and was allowed to continue to provide care to residents which was not in compliance with their policy. The facility's policy regarding abuse revised (MONTH) 16, (YEAR), revealed it is their policy that the resident(s) will be protected from the alleged offender(s). Staff accused of alleged abuse will be placed on administrative leave pending the results of a thorough investigation.
F 0686 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, interviews and policy review, the facility failed to ensure that one resident (#222) with a pressure ulcer received the necessary treatment and services to promote healing. The deficient practice resulted in a delay in wound treatment being initiated, a lack of thorough assessments being completed and consistent monitoring of the pressure ulcer at least weekly, and the wound was discovered to have deteriorated. Findings include: Resident #222 was admitted to the facility on (MONTH) 21, 2019, with [DIAGNOSES REDACTED]. A Braden Scale dated (MONTH) 21, 2019 revealed a score of 14, which indicated the resident was at moderate risk for the development of a pressure ulcer. A care plan dated (MONTH) 21, 2019 for impaired skin integrity included the following goals: demonstrate behaviors or techniques to prevent skin breakdown or facilitate healing, maintain optimal nutrition and physical well being, and verbalize understanding of condition and causative factors. Interventions were to consider nutrition services, consider use of specialty bed, inspect skin every shift, maintain clean, dry skin at all times, reposition frequently while mobility impaired, teach behaviors or techniques to prevent skin breakdown or promote healing and teach proper nutrition and hydration for prevention maintenance and repair. Review of an incision/wound/skin assessment dated (MONTH) 21, 2019 performed by a floor nurse revealed the resident had a flat, localized maroon [DIAGNOSES REDACTED] (redness) area on the medial sacrum, with surrounding tissue intact and normal in color. This assessment showed that this was over a bony prominence. The assessment did not include any measurements of the area or the type of wound. A physician's orders [REDACTED]. However, these orders did not include any wound treatment to the [DIAGNOSES REDACTED] area on the medial sacrum. A functional abilities assessment dated (MONTH) 22, 2019 revealed the resident was at substantial/maximal assistance for rolling left and right and was dependent with toileting, hygiene, wheelchair mobility and chair to bed transfers. A cognitive-linguistic evaluation dated (MONTH) 22, 2019 revealed a brief interview for mental status score a 4 out of 15, indicating severe cognitive impairment. Review of an incision/wound/skin assessment dated (MONTH) 22, 2019 performed by a floor nurse revealed the resident had a flat, non-blanchable pink-red localized [DIAGNOSES REDACTED] area on the medial sacrum, with surrounding tissue intact and normal in color. There were no measurements of the area and the type of wound was not defined. Review of an incision/wound/skin assessment dated (MONTH) 23, 2019 performed by a floor nurse revealed the resident had a localized purple pressure ulcer on the medial sacrum, with attached edges and surrounding tissue showing [DIAGNOSES REDACTED] on intact skin. The pressure ulcer measured 2.5 cm in length by 3 cm width. The documentation included the wound had deteriorated, and described it as denuded and darker red, with no signs or symptoms of infection. Per the assessment, the wound was cleaned with a commercial cleansing solution and a foam dressing was applied. However, further review of the clinical record revealed there was no documentation that the physician/nurse practitioner was notified of the pressure ulcer to the medial sacrum, and there was no treatment order for the sacrum on (MONTH) 21, 22 or 23, 2019. In addition, there was no clinical record documentation of the use of a specialty bed or mattress, which was in place from (MONTH) 21 through (MONTH) 23, 2019, as mentioned in the care plan. An incision/wound/skin assessment dated (MONTH) 24, 2019 performed by a floor nurse included the resident had a localized purple pressure ulcer on the medial sacrum, with wound edges unattached to wound bed, with surrounding tissue showing [DIAGNOSES REDACTED] on intact skin. Documentation included the wound had deteriorated and was described as denuded and darker red, with no signs or symptoms of infection. The wound was cleaned with a commercial cleansing solution and a foam dressing was applied. There were no measurements of the pressure ulcer in this assessment. A physician's orders [REDACTED]. Review of an OMBRA admission Minimum Data Set (MDS) assessment dated (MONTH) 27, 2019, revealed the resident had a BIMS score of 4, which indicated severe cognitive impairment. Per the MDS, the resident required the assistance of two staff with bed mobility, transfers and hygiene. The MDS further included that the resident had a suspected deep tissue injury. A Braden score dated (MONTH) 1, 2019 revealed a score of 13, which indicated the resident was at moderate risk for development of a pressure ulcer. A physician's orders [REDACTED]. The order also included for a consult with the wound/ostomy nurse. An observation was conducted on (MONTH) 2, 2019 at 12:26 p.m., of the resident in bed with a pressure reducing mattress in place. At this time, an interview with a family member was conducted, who stated that the resident has a bedsore near his anus and thinks that it happened here. The next pressure ulcer assessment was completed 10 days after the last assessment (November 24). According to the

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) incision/wound/skin assessment dated (MONTH) 3, (YEAR) performed by a floor nurse, the medial sacrum pressure ulcer was now described as maroon, red and yellow in color, had 90% granulated tissue and 10% slough, with a small amount of serous exudate, and the surrounding tissue had maceration and moisture. The wound measured 3.2 cm x 3.0 cm x 0.1 cm. The first assessment performed by the wound consultant was dated (MONTH) 4, 2019. Per the wound ostomy inpatient consult form dated (MONTH) 4, 2019, the sacrum had an open wound which measured 3.1 cm x 3.3 cm x 0.1 cm, with purple discoloration to the periwound. Per this document, nursing reports that slough has been present initially and is not resolving (however, there is no documentation of any slough to the wound until the (MONTH) 3 assessment), and that the wound appears consistent with a stage 3 pressure ulcer. The documentation also stated that charting indicates this wound may have initially presented as a deep tissue injury, which progressed into an open wound. Per the note, this wound nurse consultant spoke with a family member who stated that the resident did not have open wounds to the sacrum in the past. A wound observation was conducted on (MONTH) 5, 2019 at 10:00 a.m., with a RN (staff #12) and a LPN (staff #157). Staff #12 provided wound care as ordered. The wound was observed to have a pink wound bed with a flaky, macerated appearance and the wound measured 3.1 cm x 3.3 cm x 0.1 cm. During the observation, staff #12 stated that wounds are measured once a week by the charge nurse. An interview was conducted on (MONTH) 6, 2019 at 9:11 a.m., with a licensed practical nurse (LPN/staff #157), who stated that if we find a wound, then we do a wound consult. She said that she obtained a wound consult because the wound was deteriorating. She said that she doesn't see any wound consult before the one that she asked for on (MONTH) 2. She also pulled up the physician orders [REDACTED]. An interview was conducted on (MONTH) 6, 2019 at 9:30 a.m. with the Director of Nursing (DON/staff #115), who stated that her expectations for wounds was for the nurses to assess the wound, notify the physician, and obtain new orders. While reviewing the clinical record for this resident, she stated that she did not see where the nurses notified the doctor before (MONTH) 24, and that the wound consult was not requested until (MONTH) 2. She said the pressure ulcer was getting worse, but they were following it and putting interventions in place, however, she did not have any documentation of this. A follow up interview was conducted on (MONTH) 6, 2019 at 11:55 a.m., with staff #157. She stated if there is no order for wound treatment, she would immediately notify the provider and would also obtain an order for [REDACTED].>An interview was conducted on (MONTH) 6, 2019 at 12:36 p.m., with a RN (staff #37). She stated that all wounds should have a treatment order and an order for [REDACTED].#37 stated that on admission the nurse should have called the physician for a wound consultant, as it could develop into a deeper wound and get worse. She said that you don't know how deep it is when it's a deep tissue injury. She stated that they did not do a good wound assessment with measurements, until (MONTH) 23. She said the size of the wound should be included on the assessments. She stated that it might take until the next day for a wound consultant, but the nurse can put interventions in place, such as she would talk with the manager and order a special mattress, turn the resident every two hours and refer the resident to the dietician for wound healing. A copy of a text conversation dated (MONTH) 6, 2019 at 2:04 p.m. was provided by the DON. The text was between the DON and and a RN (staff #150). Per the text, staff #150 reported that she was there when the resident was admitted and that a waffle mattress was put on that night. The DON also provided a handwritten note dated (MONTH) 6, 2019 from a RN (staff #204). Per the note, staff #204 stated that she removed the waffle mattress from the bed and replaced it with an APP overlay mattress on (MONTH) 24. However, there was no documentation in the clinical record that a waffle mattress had been utilized. Review of a policy regarding Skin, Wound, and Pressure Ulcer Risk Assessment, Prevention, and Management revealed the purpose was to prevent skin injury and promote healing of wounds associated with pressure friction, shear, immobility and moisture through the use of evidence based guidelines, ongoing assessment, and coordinated treatment, so that residents may enjoy optimal health and comfort and participate to their fullest potential in daily living. The policy included that an unavoidable skin injury occurs even when a facility evaluates a resident's clinical condition and risk factors, defines and implements interventions consistent with the resident's needs/goals/recognized standards of practice, monitors and evaluates the impact of interventions, and revises the interventions as appropriate. The policy included that an avoidable skin injury occurs when the facility does not perform one or more of the above functions. The policy stated that a pressure ulcer is a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure or pressure in combination with shear and/or friction. Under the section for wound assessment, it included the following should be documented: location; wound bed; drainage; odor; color and periwound skin for [DIAGNOSES REDACTED], warmth, induration or damage. Resident's skin condition including any wounds is assessed and documented on admission and at time of treatment. Wound measurements are done on admission or wound discovery, weekly and at regular intervals. Residents identified at risk for skin breakdown will have preventative measures implemented and appropriately documented. Per the policy, pressure ulcers are staged by Wound Ostomy Continence Nurses, wound care specialists or designee, nurse practitioners and physicians.
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed clinical record review, staff interviews, and policy review, the facility failed to ensure one resident (#73) was provided adequate supervision to prevent an elopement. The deficient practice has the potential for residents to be at risk for elopement. Findings include: Resident #73 was admitted to the facility on (MONTH) 25, (YEAR) with [DIAGNOSES REDACTED]. Review of an elopement risk assessment dated (MONTH) 25, (YEAR) revealed a score of 7, which indicated the resident was at risk for elopement. A score of 5 or greater meant the resident was at risk for elopement. The assessment revealed the resident had a [DIAGNOSES REDACTED]. The assessment included addressing elopement precaution on the care plan and did not include an elopement device was in place. The admission baseline care plan dated (MONTH) 25, (YEAR) revealed the resident had no safety care problems regarding elopement wandering and to monitor the resident for adjustment to being placed in the facility. The care plan included the resident could be up with assistance and that the resident used a manual/electric wheelchair for mobility. The care plan did not include the resident was assessed to be at risk for elopement or interventions for elopement precaution. Review of the facility's mobility assessment tool dated (MONTH) 26, (YEAR) revealed the resident did not display safety awareness/alert. The admission Minimum Data Set (MDS) assessment dated (MONTH) 5, (YEAR) revealed a score of 12 on the Brief Interview for Mental Status, which indicated the resident had moderate cognition impairment. The assessment included the resident had not exhibited wandering behavior and was self-sufficient once in the wheelchair for locomotion on and off the unit. The assessment also included cane/crutch was checked for mobility devices that were normally used; wheelchair was not checked. The facility's mobility assessment tool dated (MONTH) 8, (YEAR) at 10:45 a.m. revealed the resident did not display safety awareness/alert. Review of a psychologist progress note dated (MONTH) 8, (YEAR) revealed the resident presented with cognitive dysfunction with a severity rating of at least a moderate level. A physician progress notes [REDACTED]. The resident thought she was going out to dinner with her husband and that her husband was going to put her away. The resident denied fever, chills, or urinary symptoms. The note included the resident's intermittent confusion was worse today and that the urine would be checked as this was a recent change. Review of the clinical record revealed no evidence the nursing staff had observed and assessed a change in the resident's cognition/confusion on (MONTH) 8, (YEAR). Review of a nursing note dated (MONTH) 8, (YEAR) at 8:18 p.m. revealed visitors reported that upon entering the facility, they saw a woman in a wheelchair just outside the front door. The visitors stated the woman was talking and not making any sense. The note included the writer went to the front entrance and saw resident #73 in a wheelchair approximately 30 feet from the entrance with a staff member beside her. The resident appeared confused and believed there was danger inside of the facility.

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) Another nursing note dated (MONTH) 8, (YEAR) at 8:28 p.m. revealed this writer heard staff talking about a resident being outside. The writer went outside and found the resident in front at the parking area with one of the staff. The resident was confused, thinking that someone was trying to blow up the place. The writer was able to convince the resident to go inside. Notifications were made to the physician and family. The note included staff were given instructions to keep a close eye on the resident and that a wander guard would be put on. Review of a physician progress notes [REDACTED]. The noted included the resident was started on an antibiotic and would follow cultures. An interview was conducted with the front lobby receptionist (staff #90) on (MONTH) 4, 2019 at 10:46 a.m. She stated her work hours are from 8:00 a.m. until 5:00 p.m. with a 30 minute lunch break. Staff #90 stated that when she is having lunch and when she leaves for the day at 5:00 p.m., there is no staff at the front lobby desk. She stated a sign is placed on the counter when she not there. Staff #90 stated the sign instructs to proceed down the hall to the nurse's station for assistance. She stated that if a resident is confused and does not have a wander guard, the resident would be able to leave the facility through the front doors when no staff is present. Staff #90 stated that if a resident has a wander guard and tries to leave through the front doors; an alarm would sound to alert the staff. During an interview conducted with a Certified Nursing Assistant (staff #97) on (MONTH) 4, 2019 at 1:25 p.m., staff #97 stated that if a resident has a change in their usual condition and becomes confused she must immediately report this change to a nurse. An interview was conducted with a Registered Nurse (staff #114) on (MONTH) 6, 2019 at 9:35 a.m. She stated that for an elopement risk assessment with a score of 7, a wander guard should be placed on the resident. Staff #114 stated she was unsure why resident #73 did not have a wander guard. Staff #114 stated the admission elopement risk assessment for resident #73 was incorrect because the resident had the ability to be independently mobile (which would have increased the score to 10). Staff #114 further stated the provider is usually very good about alerting the nursing staff when a resident has a change. The Registered Nurse stated that on (MONTH) 8, (YEAR), the provider should have told the staff about the change in the resident's cognition/confusion. Staff #114 stated that if the provider had notified them, maybe they would have kept a closer eye on the resident. An interview was conducted with the Director of Nursing (staff #115) on (MONTH) 6, 2019 at 10:44 a.m. Staff #115 stated an elopement risk assessment is completed for a resident on admission and that if the resident is assessed to be a high risk, a wander guard would be placed on for safety. She stated the expectation is that the elopement risk assessment be accurate. She stated the front lobby area is unsecured after 5:00 p.m. and a resident who is confused and without a wander guard, could exit the facility without staff knowing. The Director of Nursing stated that the provider did not notify the staff of the change in resident #73 on (MONTH) 8, (YEAR) so the staff were not aware of the resident's change in cognition/confusion. The facility's policy regarding elopement revised (MONTH) 16, (YEAR) revealed elopement is the ability of a resident who is not capable of protecting themselves from harm to successfully leave the facility unsupervised and unnoticed and who may enter into harm's way. The purpose included implementing prevention strategies for those residents identified as an elopement risk. A facility provided risk assessment tool or scoring system is utilized. The risk score includes a defined parameter which, when reached, indicates an increase risk and prompts prevention strategies. Interventions that may be used for residents identified as high risk for elopement included frequent monitoring of the resident's whereabouts to assure the resident remains in the facility (e.g., every one-half hour check) and implementation of alert device or other electronic alert systems. The policy also included if a resident is identified as moderate to high risk for elopement, establish an interim plan of care.