STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355124	A. BUILDING _____ B. WING _____	C 11/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CROSSINGS CARE CENTER/TCU	125 13TH AVENUE WEST WEST FARGO, ND 58078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the unannounced complaint survey conducted 11/29/16, the sample included three residents for focused review.	F 000		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on information received from the complainant, observation, record review, resident interview, and family interview, the facility failed to provide care and services to manage	F 309	F 309 1. Resident #1 Care Plan has been updated to include resident wanders into other residents□ rooms focus effective	1/3/17

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

Electronically Signed | 12/19/2016

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F 309	Continued From page 1 behavioral symptoms of dementia for 1 of 1 sampled resident (Resident #1) with wandering behaviors. Failure to promptly assess wandering behavior, implement an effective behavior management plan in a timely manner, and periodically re-evaluate existing interventions and implement additional interventions resulted in continued and intrusive wandering into other resident's rooms, contributed to two resident falls (Resident #2 and #3), and negatively impacted the quality of life for several residents (Resident A, B, C, and D). Findings include: Information received from the complainant identified concerns regarding a resident (Resident #1) wandering into others' rooms. Confidential interviews during the survey revealed the following: Resident A: *Resident #1 enters her room "quite often... more than once is often enough." *"Naturally I'm scared, it's an eerie feeling when you see a man coming into your room." *Has seen Resident #1 enter several other residents' rooms Resident B: *Resident #1 enters her room "a couple times a day" *Resident #1's wandering is "annoying... I'm not scared of him. A couple of the other ladies are, though." *"It really is a problem [Resident #1's wandering]."	F 309	July 2016. Interventions for other residents being affected by resident□s wandering have been added to Resident #2 and Resident #3□s care plans. Resident #1 has changed rooms 12/18/16. This room change is to trial a new unit, room orientation, and location in regards to hallway, wandering path, etc. Resident #2- To help with bothersome behavior of other residents, facility will continue to assess concerns and appropriate interventions, taking into account both residents diagnoses, physical conditions, environmental circumstances, and concerns. Fabric stop sign was added to Resident #2□s door 12/12/16. Resident #2□s care plan has been updated 12/12/16 to include focus, Resident has voiced concerns regarding other residents wandering into her room. Resident #3-will continue to assess concerns and appropriate interventions, taking into account both residents diagnoses, physical conditions, environmental circumstances, and concerns. 2. Residents with the potential to be affected include residents with behavior of wandering into other residents rooms and residents voicing concerns of other residents wandering into rooms. 3. Residents with the behavior of wandering into other resident rooms will be assessed, and addressed on their individualized care plan. Appropriate interventions will be trialed and implemented when effective. Residents bothered by other residents	

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F 309	Continued From page 2 *"I don't want some man going through my things." Resident C: *Resident #1 enters her room "quite a bit." *"They [the staff] say he bothers quite a few others." *Resident #1's wandering "happened a couple times at night. [I] was in bed sleeping, I sensed something and woke up." *"Scares me when it's [the wandering] at night. You feel so secure and then he comes in." *"The idea that he can get by with it bothers you." *On one occasion, Resident #1 attempted to enter her room and another resident "grabbed his wheelchair and pulled him out. She said 'he bothers me too.' Little stinker." *"If I could get up and push him out, I would." Resident D: *Resident #1 enters her room "a few times per month" *"I'm not scared, I just don't like what he's doing and when he's doing it." *"It's unnerving, it happens usually at night when I'm sleeping." *"He's a pill." He "sneaks in, like a cat." *Resident #1 "has come up to my bed and touched my leg." Family Member A: *Resident #1 wanders into her family member's room "quite often, and I've seen him go into others' rooms too." *"This is her [family member's] private room, she doesn't want him [Resident #1] in here." *"I know it bothers her." "He's [Resident #1] really	F 309	wandering behavior will be assess. For those residents whom individualized interventions have been added, Care Plan will reflect focus areas and interventions. 4. January 3, 2017 5. Auditing by DON or designee for 1) residents with behavior of wandering into other resident rooms to have individualized interventions on Care Plan, 2) Residents affected by other resident□s behavior to have documentation that situation addressed, and Care Plan updated as needed. Auditing to take place 3x/week for 4 weeks, 2x/week for 8 weeks, 1x/week for 12 weeks and prn. QAPI process followed to include improvements effective sustained and continued trial of necessary changes. Quality Committee to review and provide recommendations prn.	

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F 309	Continued From page 3 the only problem here." - Review of Resident #1's medical record occurred on 11/29/16. Diagnoses included dementia without behavioral disturbance and insomnia. The Minimum Data Sets (MDS's) identified the following increase in wandering behavior: *01/29/16: Wandering occurred zero days during the look back period *04/29/16: Wandering occurred 1 to 3 days during the look back period *07/29/16: Wandering occurred 1 to 3 days during the look back period *10/29/16: Wandering occurred 4 to 6 days during the look back period. This current MDS also identified severe cognitive impairment. Current medications included Celexa (an antidepressant) 5 milligrams (mg) daily (re-started 07/18/16). Resident #1's progress notes revealed the following: *03/01/16 at 5:18 p.m.: ". . . Reported by another resident to be wandering into other resident's rooms at night. IDT [interdisciplinary team] updated. Will put interventions in place to try to deter resident from wandering into others' rooms. . . ." *03/20/16 at 5:10 a.m.: ". . . Another resident was very upset with this resident d/t [due to] this resident being in her room in the middle of the noc [night] and playing with her balloons and taking her glasses. Resident redirected out of the room. Has been awake the majority of the noc. Has had 1:1 with staff, snack and fluids, and has been moving about the unit in his wheelchair. Has not attempted to go back in other resident's	F 309		

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F 309	Continued From page 4 room. . . ." *03/25/16 at 5:40 a.m.: ". . . Throughout PM [evening] shift and part of the noc, resident was wondering [sic] up and down hallways and in and out of other resident's rooms. Resident was redirected several times by staff and residents. Resident was easily redirected but would eventually go into someone else's room. Interventions used with resident were 1:1 with staff, snack, and moving resident into his room to watch TV. All were successful for short periods. . . ." *03/28/16 at 1:45 p.m.: ". . . updated family on follow up appointment for the 30th of June et [and] also [Resident #1] wandering the unit at night time. [Daughter] said that we should try to keep him busy during the day so he sleeps at night. . . ." *03/29/16 at 3:55 a.m.: ". . . Resident roamed around back lounge area on PM shift. Staff noted resident attempted to go in one room but was easily redirected. . . ." *04/11/16 at 3:45 a.m.: ". . . Late Sunday afternoon and into the evening, resident was continuously entering other resident's room. Resident would become agitated with staff for attempting to redirect him and turn around and go into another resident's room. . . ." *04/16/16 at 5:15 p.m.: ". . . Resident wandering this evening. Resident sitting in doorway's of other residents rooms. Other residents expressed they were upset. Resident redirected. . . ." *04/16/16 at 5:41 p.m.: ". . . Resident wandering into another residents room. . . ." *04/17/16 at 6:30 p.m.: ". . . Resident wandering around and found in another residents room. Resident redirected. Resident refused supper	F 309		

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F 309	Continued From page 5 and continues to wander . . ." *04/25/16 at 4:56 p.m.: ". . . Quarterly therapeutic recreation assessment completed. Resident is hard to direct to activities and does not stay long when he does come to activities. This is not new, but he does seem to sleep more during the activities than he attends. He does observe exercises in the mornings if they are by his room. He also will come to music socials, but will not stay long. Staff do visit with him and he is on the 1:1 visit list. . . ." *04/27/16 at 5:01 p.m.: " . . . Resident wakes often through out [sic] the night and wanders into other residents rooms. Resident is redirected. . . . " *04/28/16 at 3:36 p.m.: ". . . Resident appears to have little interest in doing things. Unable to keep attention at activity events. He prefers to wheel around unit or visit one on one. Resident has trouble sleeping at night and will wander into other resident's rooms. Staff attempt to deter. Takes melatonin to help with sleep half or more of the nights. . . ." *05/09/16 at 7:50 a.m.: ". . . Sunday night resident slept until approx [approximately] 0400 [4:00 a.m.] and then he was up motoring about the unit and going in and out of other resident's rooms. Resident easily redirected but soon after would be heading into another resident's room. . . ." *05/16/16 at 1:43 p.m.: ". . . Reviewed resident continues to be awake at night and wander. Staff redirect and at times can be difficult to redirect. Wanders into other residents room at times and staff remove and redirect resident. Resident wandered off unit recently to back chapel doors. . . . Reviewed resident does not attend activities often, used to stay for a short period but no	F 309		

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F 309	Continued From page 6 longer staying for activities due to attention span. . . ." *06/11/16 at 6:00 a.m.: ". . . Resident had increased wandering @ HS [night time], going into at least three different resident's rooms. Two of them he went into the bathroom and the other he was found lying on the resident's bed. All three residents were female and were upset by this resident's actions. . . ." *07/08/16 at 7:40 a.m.: ". . . Staff/residents report that over the past few days, resident has been in and out of other resident's rooms, upsetting the other residents. . . ." *07/14/16 at 4:27 a.m.: ". . . resident up in wheelchair, has been attempting to go out EXIT doors, and asks how he can get out of here, also has been wandering into resident room, resident 1:1 care. . . ." *07/17/16 at 3:33 p.m.: ". . . [Resident #1] was observed being propelled out of another resident's room by that resident. Other resident stated that [Resident #1] has entered her room several times in the last few days. . . ." *07/17/16 at 9:05 p.m.: ". . . resident wandering into several rooms, resident reoriented to his room, resident also attempted to go out through exit door between rooms 45 and 46. . . ." *07/18/16 at 11:36 a.m.: ". . . [daughter] called back and updated r/t resident's increased wandering and decreased sleep at night. . . . [healthcare practitioner] updated r/t residents increased wandering, disrupting other residents, and resident not sleeping well. . . . start Celexa [an antidepressant] 5 mg [milligrams] daily and decrease melatonin back to original order of 3 mg at HS . . ." *07/18/16 at 11:41 a.m.: ". . . Resident redirected out of another residents room. . . ."	F 309		

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F 309	Continued From page 7 *07/21/16 at 12:32 p.m.: ". . . NOC nurse reported to this nurse that resident was wandering last evening into other residents room. Resident redirected. . . ." *07/29/16 at 12:09 p.m.: ". . . Quarterly therapeutic recreation assessment completed. Resident does sleep during most activities and when he does come, does not stay long. Resident did listen to iPod with music and he did seem to enjoy that. Resident is also on the 1:1 visit list and enjoys hitting the balloon and playing balloon toss. . . ." *07/30/16 at 1:37 p.m.: ". . . Resident appears to have little interest in doing things as he will wander away from activities. He wheels around unit or appears to enjoy simple conversation one to one. Resident has difficulty staying asleep at night. He wanders into other resident's rooms. Staff attempt to deter. Takes melatonin and Celexa restarted recently. Some improvement noted with sleeping at night since restarting of Celexa. . . . " *07/30/16 at 2:43 p.m.: ". . . Resident noted x2 attempting to wander into room #46. Door closed to room and resident attempted to grab door handle. Staff note resident previously entered this room earlier today. Stop signs placed on other resident's door to deter wandering into this room. Resident removed from area of this room both times. Distraction attempted and resident provided a snack. Also, attempted to engage resident in activity. Proved [sic] resident a tackle box with fishing tackle items. . . ." *07/30/16 at 5:15 p.m.: ". . . Resident wandering into several different residents rooms this afternoon. Resident redirected. . . ." *08/02/16 at 8:19 a.m.: ". . . resident wandered into another residents room at 0630 [6:30 a.m.]	F 309		

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F 309	Continued From page 8 this morning causing the resident to scream and scream at resident. Resident was removed by CNA [certified nursing assistant] and brought to his room. . . ." *08/03/16 at 5:52 p.m.: ". . . Resident wandering into other residents rooms this afternoon. Staff redirected et will continue to monitor. . . ." *08/05/16 at 8:37 p.m.: ". . . resident wandering into resident rooms #46 and #63, resident redirected to room. . . ." *08/08/16 at 3:06 p.m.: ". . . Resident wandering in other resident's rooms during the lunch hour. Resident redirected. Staff will continue to monitor. . . ." *08/17/16 at 11:03 a.m.: ". . . Update provided regarding Resident continues wandering quite a bit the last several nights. Wanders into to [sic] other resident's rooms. Usually says a few words and then turns around and leaves. Appears to go to one resident's room for candy. [daughter] agreeable to provide candy for resident in a dish in his room. . . ." *08/18/16 at 5:13 a.m.: ". . . Resident in and out of other resident's rooms on PM shift. Other resident becoming very upset. One resident's husband came to get this writer d/t [due to] resident attempting to get undressed in the resident's room. . . ." *08/20/16 at 5:45 p.m.: ". . . Resident wandering into room 45, resident redirected. . . ." *08/21/16 at 9:37 a.m.: ". . . Night nurse reported to this nurse that resident was wandering into room 46. Resident redirected et staff will continue to monitor. . . ." *08/29/16 at 11:42 a.m.: ". . . NOC nurse reported to this nurse that resident was wondering [sic]. Staff will continue to monitor. . . . " *08/31/16 at 3:00 p.m.: ". . . Resident wandering	F 309		

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F 309	Continued From page 9 into room 50. Staff will continue to monitor. . . . " *08/31/16 at 5:04 p.m.: ". . . Resident wandering into room 47 and 45. Resident redirected. Staff will continue to monitor. . . ." *09/10/16 at 6:10 p.m.: ". . . Resident wandering into room 44. Resident redirected and staff will continue to monitor. . . ." *09/11/16 at 11:45 a.m.: ". . . Resident wandering into room 59, resident redirected et staff will continue to monitor. . . ." *09/15/16 at 8:42 a.m.: ". . . NOC nurse reported to this nurse that resident was awake all evening and wondering [sic]. Resident redirected et staff will continue to monitor. . . ." *09/27/16 at 3:37 a.m.: ". . . resident wandered into room #46, CNA took resident to lounge area by his room. . . ." *09/30/16 at 4:02 p.m.: ". . . Spoke with daughter . . . notified her of resident's wandering frequency increasing recently. Also informed her of distraction techniques we will implement such as offering snacks or activities when resident begins wandering. . . ." *10/17/16 at 10:25 p.m.: ". . . resident wandering was taken out of room #59 . . ." *10/25/16 at 9:11 p.m.: ". . . resident found in room #47, redirected snack was given . . ." *10/25/16 at 8:24 p.m.: ". . . He is at high risk for falls and wanders. Resident will often enter other resident's rooms. . . ." *10/27/16 at 1:03 a.m.: ". . . resident wandered into room #59 . . ." *10/27/16 at 2:20 p.m.: ". . . Resident wanders around the facility and has little attention span. He wheels around unit or appears to enjoy simple conversation one to one. Resident has difficulty staying asleep at night. He wanders into other resident's rooms. Staff attempt to deter by	F 309		

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F 309	Continued From page 10 offering snacks. . . ." *10/27/16 at 8:25 p.m.: ". . . resident wandered into room #55, redirecting ineffective as resident keeps wheeling himself towards room after being taken to his room. . . ." *10/31/16 at 1:12 p.m.: ". . . Quarterly therapeutic recreation assessment completed. There is no significant change with residents activity level. Resident does not like to stay for activities unless there is a snack provided. Even with a snack, he will usually roam back to his room where he seems to be most content. Resident is on the 1:1 visit list 2x/week where he enjoys playing balloon toss. The music therapist has also been singing to resident and he does enjoy that. Staff will continue to try to get resident to activities of interest. . . ." *11/02/16 at 8:30 p.m.: ". . . resident found on floor in room 58, back leaning against drawer, under 58A med [medication] drawer, resident was fully dressed, brief dry, socks and shoes on, lighting in room was dark . . . there is a red area to right side of head, skin broke but not bleeding . . ." *11/07/16 at 10:08 a.m.: ". . . Reviewed behavior of wandering into others' rooms and interventions used including snack bags. . . ." *11/15/16 at 6:50 p.m.: ". . . resident attempted to go outside through door 22. Staff notified due to alarm sounding. . . ." *11/15/16 at 7:15 p.m.: ". . . resident in room 58B, in wheelchair, next to resident bed, resident legs hanging off the bed, sheets taken off of resident, staff notified by call light, [Resident #1] was repeating 'we gotta go,' when staff walked in room . . ." *11/16/15 at 3:55 p.m.: ". . . Per night LPN [licensed practical nurse], resident was found at	F 309		

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F 309	Continued From page 11 the first door after sounding the alarm by pushing the bar. Resident did not exit the building and was redirected away from the door. . . ." *11/29/16 at 5:00 p.m.: ". . . This nurse found resident trying to get into Room 79 (Support Room) which is locked. This nurse asked resident if he wound [sic] like some ice cream for a snack. He said that he would and we went to get ice cream. . . ." Resident #1's care plan identified the following: *Activities: "Resident will participate in activities of interest to him. . . . Interventions . . . Activity calendar will be posted in my room [revised 05/05/2015] . . . Encourage resident to share activity ideas they would like to pursue [created 03/08/2013] . . . Encourage resident to socialize with others during activities while observing if declines participation [created 04/25/2016] . . . If resident seems agitated, try the Music and Memory iPods on each unit [created 07/29/2016] . . . Provide resident with new and old recreational opportunities daily [created 03/08/2013] . . . Resident's preferred activities are: listening to music, visiting with animals (likes dogs), some group activities, attending religious services (may not stay), exercise (observes, balloon toss and intergenerational activities [revised 10/31/2016] . . . Staff will provide recreational area for resident to engage in activities of his choosing with residents and family [revised 03/08/2013] . . . Staff will provide resident with invitation to participate in daily activities [created 03/08/2013] . . . " The activities care plan lacked individualized interventions specific to Resident #3's needs (i.e. 1:1 visits and preferred activities during those	F 309		

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	355124	A. BUILDING _____ B. WING _____	C 11/29/2016

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F 309	Continued From page 12 visits, candy dish in his room, use of music therapist, etc.) *Wandering: "Resident wanders into other resident's rooms [created 07/30/2016] . . . Interventions . . . Bookshelf decal placed on other resident's room door that he wanders into to deter wandering [revised 11/29/2016] . . . Celexa restarted [created 07/30/2016] . . . Mood and behavior monitoring per facility policy [created 07/30/2016] . . . Offer snacks when resident is wandering [created 11/10/2016] . . . Provide consistent caregivers as able [created 07/30/2016] . . . Report changes in behavior to practitioner and family [created 07/30/2016] . . . Staff monitor resident and redirect when entering or attempting to enter another resident's room [created 07/30/2016] . . ." Although staff noted Resident #1's wandering as early as March 2016, staff did not initiate a care plan with individualized interventions related to wandering until 07/30/2016. The medical record lacked evidence of re-evaluation/modification of current behavior management techniques except the addition of offering a snack on 11/10/16. The care plan also lacked information related to distraction techniques to attempt (such as snacks or personalized activities specific to the resident's interests/abilities) during periods of wandering (as identified in the nurse's note dated 09/30/16). Observations throughout the survey identified Resident #1 self-propelled around the unit/hallways in his wheelchair. On 11/29/16 at 4:48 p.m., observation showed Resident #1 attempting to open a locked closet door near the nurses' station. An unidentified staff member approached the resident and offered him ice	F 309		

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F 309	Continued From page 13	F 309		

cream. The resident ate the ice cream and continued self-propelling down the hallways.

- Review of Resident #2's medical record occurred on 11/29/16. Diagnoses included left below the knee amputation. The resident's current MDS, dated 11/21/16, identified intact cognition. Resident #2's current care plan stated, ". . . Potential for falls . . . Interventions . . . Independent with transfers, assist per resident's request . . . Wheelchair next to bedside when resident is in bed. . . ."

The medical record identified a fall which occurred 10/13/16. During an interview on the morning of 11/29/16, Resident #2 identified Resident #1 was in her room earlier on the evening of 10/13/16 and moved her wheelchair. The resident stated she put on her call light for transfer assistance to her wheelchair, because the wheelchair was too far away from her. Resident #2 stated, "I couldn't wait anymore; I had to go to the bathroom so bad." The resident stated she then attempted to transfer herself to her wheelchair, and fell. Resident #2 stated, "It was degrading, you know? I had to pee on the floor." Resident #2 further stated Resident #1 enters her room daily, sometimes multiple times per day, and "He really is a pest. They wanted me to move, but I like my room." The resident also identified the staff had tried putting a black rug in front her of her door, and a bookshelf decal and a mirror on her door. Resident #2 identified these interventions did not work, and she did not always want to have her door closed either. Resident #1's progress notes lacked information related to this fall.

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F 309	Continued From page 14 Social services progress notes identified the following: *03/01/16: ". . . Approached by [daughter] today. She was upset because she reports resident is unable to sleep at night without Xanax [an anti-anxiety medication] due to another resident coming into her room at night. Reassured her staff would work with other resident to attempt to prevent/deter this from occurring. . . ." *03/03/16: ". . . Care conference held. . . . Utilizing her prn [as needed] Xanax to help her sleep in recent nights due to trouble sleeping/anxiety due to another resident wandering into her room. Staff working with other resident on interventions . . ." *04/07/16: ". . . Met with resident and inquired how things were going with the other resident that wander [sic] into her room . . . Resident states she think [sic] she's getting used to it as she does not notice either happening much but believes it is still an issue. . . ." *04/08/16: ". . . Resident offered room change . . . Resident declined stating 'I think those 2 should have to move.' . . ." *06/06/16: ". . . Other resident who wanders into her room is not problematic for her as she states he enters her room and leaves quickly and this does not bother her. . . ." *08/02/16: ". . . Discussion held with resident regarding another resident wandering into her room. She states the book shelf decal does not prevent him from entering her room on a near daily basis and is agreeable to its removal from her door. . . ." *10/13/16: ". . . Spoke with [daughter] who voiced concerns regarding thinking resident's fall was caused by another resident wandering into her room last night and moving the chairs in her	F 309		

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F 309	Continued From page 15 room, including her wheelchair. States she also feels the fall could have been related to increased [sic] resident has been reporting to her which began 6 weeks ago. States she she [sic] has had pain and weakness in her arms and leg. . . . IDT to discuss prevention interventions for wandering resident. . . . " 11/21/16: ". . . Resident reports wandering resident 'does not bother me.' States other resident does at times enter her room tough [sic] leaves without touching her belongings. She declined offer of trying mirror on her door stating she worried he would see his reflections and want to come in and visit as he did this when her son is in her room visiting. . . ." - Review of Resident #3's medical record occurred on 11/29/16. The resident's current MDS, dated 10/03/16, identified intact cognition. The care plan stated, ". . . Potential for falls . . . Interventions . . . Ambulation: 1 ASSIST with walker [revised 11/28/16] . . . Transfers: Assist of 1 with walker. . . ." Resident #3's progress notes identified the following: *09/29/16 at 3:34 p.m.: ". . . Resident is not at fall high risk and has had no falls this quarter. . . ." *09/29/16 at 7:34 p.m.: ". . . Fall . . . Resident was found on floor on left side. She stated that another resident was wheeling into her room and she was trying to get him out by walking toward him with her walker and she fell. . . . c/o [complains of] pain in left elbow area 10/10. Has 10 cm [centimeter] by 2.5 cm purple bruised area with tenderness just below elbow on outer arm with slight swelling to area . . ." *10/13/16: ". . . Another resident continues to	F 309		

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F 309	Continued From page 16 wander into resident's room and reminded resident to avoid trying to remove him from her room rather put on her call light and staff will assist him out. Staff will also continue to try to deter resident from wandering into he [sic] room. . . ." During an interview on the morning of 11/29/16, Resident #3 identified she fell "a couple months ago." She stated Resident #1 entered her room and she was "trying to shoo him out and I fell." Resident #1 identified at the time of the fall, she could ambulate by herself using a walker. She identified Resident #1 enters her room "quite often" and "I get so disgusted." The facility failed to implement an effective behavior modification program to manage Resident #1's behaviors which resulted in continuous, intrusive wandering that negatively impacted residents' psychosocial well-being and resulted in Resident #2 and #3's falls.	F 309		
F9999	FINAL OBSERVATIONS The complaint issue regarding call lights could not be substantiated.	F9999		