

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/26/2024
NAME OF PROVIDER OR SUPPLIER  Jefferson Manor Nursing and Rehab Ctr, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  9919 Jefferson Hwy. Baton Rouge, LA 70809	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49343</b></p> <p>Based on record review and interviews, the facility failed to ensure an allegation of neglect was reported to the State Survey Agency in the required timeframe for 1 (#1) of 5 (#1, #2, #3, #R1 and R2) sampled residents reviewed for elopement.</p> <p>Findings:</p> <p>Review of the facility's Abuse/Neglect Prevention Program policy (Revised 09/08/2021) revealed the following in part: B. Neglect: Neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. A Nursing Facility must report to the State Survey Agency incidents of alleged neglect and all situations in which a Nursing Facility has cause to believe that the physical or mental health and/or welfare of a resident has been or may be adversely affected by neglect caused by another person. Neglect may include but is not limited to: Failure to provide adequate supervision .</p> <p>In the event of any evidence involving neglect, an occurrence will be reported immediately to the Administrator of his or her designee of the facility, who will immediately notify corporate office and the appropriate state officials per state guidelines.</p> <p>Review of the facility's Mandated Reporting Flowsheet revealed the following in part: Does the incident or allegation involve neglect, exploitation or other reportable incident that poses a threat to the resident's health and safety but does not result in serious bodily harm? Report immediately to the Administrator, but not later than 24 hours to the State Survey Agency.</p> <p>Review of Resident #1's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses, including: Type 2 Diabetes Mellitus with Hyperosmolarity Without Nonketotic Hyperglycemic-Hyperosmolar Coma, Undifferentiated Schizophrenia and Disorganized Schizophrenia.</p> <p>Review of Resident #1's 12/2024 Physician's Orders revealed in part: Visual check for resident's location every 2 hours, every shift. Start date: 09/03/2024.</p> <p>Review of Resident #1's Nursing Progress Note dated 12/14/2024 at 11:38 a.m. revealed the following, in part:</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident not noted in his room at breakfast time. Asked his roommate, but he was unsure. Checked rooms on the hallway and the shower. Checked the patio areas. Notified RN Supervisor and CNA Supervisor. Call placed to S4ADON by RN Supervisor. S4ADON called and informed S2ADM. Call placed to Resident #1's brother-in-law at 10:15 a.m. to let him know resident was missing. Resident #1's sister called back about 10:50 a.m. and spoke to S2ADM. Staff drove on nearby highway to look for Resident #1 but were unsuccessful. After review of the facility's video footage, it appeared resident climbed over the fence on patio at about 4:30 a.m. Call placed to Resident #1's physicians on call answering service. Signed by: S5LPN</p> <p>Review of facility's Incident Investigation Report dated 12/14/2024, titled Elopement revealed documentation Resident #1 elopement from the facility on 12/14/2024.</p> <p>On 12/19/2024 at 2:45 p.m., an interview was conducted with S11CNA. She stated she worked the 6:00 a.m. to 2:00 p.m. shift on 12/14/2024 and she was the CNA assigned to Resident #1 on 12/14/2024. She stated on 12/14/2024 at approximately 7:30 a.m. she walked in Resident #1's room and she only saw his roommate in bed and she did not see Resident #1. She stated she notified S5LPN, Resident #1's nurse that Resident #1 was not in his room.</p> <p>On 12/20/2024 at 1:05 p.m., a telephone interview was conducted with S5LPN. He stated he worked on 12/14/2024 and was the nurse assigned to Resident #1 that day. He stated he did not see Resident #1 come get his morning medication on 12/14/2024 before breakfast around 7:00 a.m. He stated after searching for Resident #1 he notified the RN supervisor on weekends and the CNA supervisor. He stated staff searched the facility for Resident #1 and were unable to locate him. He stated at that time the weekend supervisor notified S4ADON and S2ADM.</p> <p>On 12/26/2024 at 2:10 p.m., an interview was conducted with S2ADM. S2ADM stated Resident #1 was missing for four days and no staff had physically seen him from 12/14/2024 until he was found on 12/18/2024. He stated he was notified by staff on 12/14/2024 at approximately 9:00 a.m. that Resident #1 was not on the property and no one could find him. He confirmed by reviewing the facility surveillance footage, Resident #1 was seen leaving the facility on 12/14/2024 at 4:32 a.m. He confirmed staff failed to adequately supervise Resident #1 by not performing visual checks every two hours on Resident #1 as ordered. S2ADM further confirmed he did not report the incident to the State Survey Agency.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49343</p> <p>Based on record review, video observation, and interviews the facility failed to ensure residents received adequate supervision to prevent elopement from the facility for 1 (#1) of 5 (#1, #2, #3, R1 and R2) sampled residents reviewed for elopement.</p> <p>This deficient practice resulted in an Immediate Jeopardy (IJ) situation on 12/14/2024 at 4:32 a.m. when Resident #1, a moderately cognitively impaired resident with a physician's order for staff to visually check the resident every 2 hours, eloped from the facility. On 12/14/2024, staff last visualized Resident #1 at approximately 4:00 a.m. Resident #1 was observed on video footage eloping from the facility by climbing over the patio fence at 4:32 a.m., without staff knowledge. Facility staff had not realized Resident #1 eloped from the facility until approximately 8:00 a.m. The resident was found by local police officers at a local gas station on 12/18/2024 at approximately 2:38 p.m.</p> <p>S2ADM was notified of the Immediate Jeopardy on 12/19/2024 at 6:14 p.m.</p> <p>This deficient practice continued at a likelihood to cause more than minimal harm to the remaining 100 residents residing in the facility with orders to be visually checked.</p> <p>The Immediate Jeopardy was removed on 12/20/2024 at 2:03 p.m., when it was determined the facility had implemented an acceptable Plan of Removal as confirmed through onsite interviews, observations, and record review.</p> <p>Findings:</p> <p>Review of the facility's undated policy, titled Wandering or Missing Resident, read in part . Procedure: 4. Any staff member becoming aware of a resident not being at the designated area or activity shall proceed to notify the charge nurse, Director of Nursing and the Administrator.</p> <p>Review of Resident #1's Clinical Record revealed he was admitted to the facility on [DATE], and had diagnoses which included in part, Type 2 Diabetes Mellitus, Undifferentiated Schizophrenia and Disorganized Schizophrenia.</p> <p>Review of Resident #1's Quarterly Minimal Data Set (MDS) with an Assessment Reference Date (ARD) of 08/21/2024, revealed a Brief Interview for Mental Status (BIMS) of 12, which indicated Resident #1 had moderate cognitive impairment.</p> <p>Review of Resident #1's 12/2024 Physician's Orders revealed in part: Visual check for resident's location every 2 hours, every shift. Start date: 09/03/2024.</p> <p>Review of Resident #1's Nurses' Note dated 12/2024 revealed the following, in part:</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 12/14/2024 at 11:38 a.m., Resident not noted in his room at breakfast time. Asked his roommate but he was unsure. Checked rooms on the hallway and the shower. Checked the patio areas. Notified RN supervisor and CNA supervisor. S4ADON called and informed S2ADM. Call placed to Resident's brother-in-law at 10:15 a.m. to let him know that resident was missing. Resident's sister called back about 10:50 a.m., and spoke to S2ADM. Staff drove on local highway to look for resident but were unsuccessful. After replaying the video footage resident climbed the patio fence at approximately 4:30 am. Call placed to physicians on call answering service. Signed by: S5LPN.</p> <p>Review of a written statement from S6CNA dated 12/14/2024 revealed the following: Upon arriving I did my room rounds, all residents was accounted for. Around 3:00 a.m. or 4:00 a.m., Resident #1 came out room to get ice and walk hall, this is a regular routine. On my last round, I went into Resident #1's room to turn his roommate, I noticed that Resident #1 wasn't in room, I finished my last round getting resident up.</p> <p>On 12/19/2024 at 10:37 a.m., a review of the facility's video surveillance footage dated 12/14/2024 from 4:00 a.m. until 9:00 a.m. was conducted with S2ADM of the hall Resident #1 resided on as well as the patio area. Review of the surveillance footage revealed on 12/14/2024 at 4:32 a.m., Resident #1 was observed using a chair to climb over the patio gate and left the facility's premises. Further review of the surveillance footage revealed staff failed to perform visual checks on Resident #1 every two hours as ordered, after he left the facility at 4:32 a.m., until 8:30 a.m. when staff are seen looking for Resident #1.</p> <p>On 12/19/2024 at 10:20 a.m., a telephone interview was conducted with S9LPN. She stated she was the nurse assigned to Resident #1 on 12/13/2024 and worked the 10:00 p.m. to 6:00 a.m. shift. She stated Resident #1 was cognitive and able to understand and be understood. She stated he was also able to ambulate independently. She confirmed Resident #1 had visual checks ordered every two hours which meant staff were to visualize the resident every two hours. She stated she conducted rounds at 10:00 p.m., 12:00 a.m., 2:00 a.m., and 4:00 a.m. She stated at approximately 4:00 a.m., she went in Resident #1's room to give his roommate medication, and saw Resident #1 in his bed. She confirmed this was the last time she visually saw Resident #1 on 12/14/2024 as her final round was at 4:00 a.m., and her shift ended at 6:00 a.m. She confirmed no staff had notified her Resident #1 had not been seen after 4:00 a.m.</p> <p>On 12/19/2024 at 1:48 p.m., a telephone interview was conducted with S6CNA. She stated was assigned to Resident #1 on 12/13/2024 and worked the 10:00 p.m. to 6:00 a.m. shift. She stated Resident #1 ambulated independently. She confirmed Resident #1 had visual checks ordered every two hours which meant staff were to visualize the resident every two hours. She stated she conducted rounds at 10:00 p.m., 12:00 a.m., 2:00 a.m., and begins her last round at about 4:00 a.m. She stated she last saw Resident #1 between 3:30 a. m. and 4:00 a.m. on 12/14/2024 getting ice from cooler in hallway. She stated she went into the resident's room to perform her last round between 4:45 a.m. and 5:00 a.m. and Resident #1 was not in his room at that time. She confirmed she did not notify staff Resident #1 was not observed during her last round, nor did she try to locate him at that time, and should have.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 12/19/2024 at 2:27 p.m., an interview was conducted with S7CNA. She stated she worked on 12/14/2024 on the 6:00 a.m. to 10:00 p.m. shift passing meal trays on Resident #1s hall but she was not his CNA for that day. She stated Resident #1 was ordered visual checks every 2 hours, which meant staff were to visualize the resident every two hours. She stated when she went in Resident #1's room around 7:30 a.m. to pass breakfast trays she asked his roommate if he had seen Resident #1. She stated his roommate said he just left out, but he would be right back. She stated she left Resident #1's tray in his room and walked out.</p> <p>On 12/19/2024 at 2:45 p.m., an interview was conducted with S11CNA. She stated she worked the 6:00 a.m. to 2:00 p.m. shift on 12/14/2024 and was the CNA assigned to Resident #1 on 12/14/2024. She stated Resident #1 was ordered visual checks every 2 hours, which meant staff were to visualize the resident every two hours. She stated she began rounding on residents at around 6:30 a.m. She stated by the time she made it into Resident #1's room it was about 7:30 a.m., and she did not see Resident #1. She stated she notified S5LPN that Resident #1 was not in his room.</p> <p>On 12/20/2024 at 1:05 p.m., a telephone interview was conducted with S5LPN. He stated he was the nurse assigned to Resident #1 on 12/14/2024. He stated Resident #1 had visual checks ordered every two hours. He stated he rounded on residents every two hours or every one hour if ordered sooner. He stated he did not observe Resident #1 come get his morning medication on 12/14/2024 before breakfast around 7:00 a.m., which was unusual since Resident #1 typically came out to the hall to receive his morning medications. He stated he asked Resident #1's roommate if he had seen him, and he answered no. He stated he asked CNAs if they had seen him and they were not sure. He stated between 8:00 a.m. and 8:30 a.m. after searching for Resident #1 and being unable to locate him, he notified the RN supervisor and the CNA supervisor that the resident could not be found. He stated staff searched the facility for Resident #1 and were unable to locate him. He stated at that time the supervisor notified S4ADON and S2ADM Resident #1 was missing from the facility.</p> <p>On 12/20/2024 at 1:50 p.m., an interview was conducted with S12CNAS. She stated at approximately 8:00 a.m. on 12/14/2024, S5LPN notified her he could not locate Resident #1. She stated she notified S13RNS and a Code W was called. She stated a Code w meant she and staff CNAs would go room to room and completed a total count of all residents. She confirmed Resident #1 was not present in the facility during the head count. She stated CNAs were expected to perform visual checks on residents every two hours and if the staff were unable to locate the resident upon visual checks they were to notify the nurse immediately. She stated nursing staff were expected to search the facility and locate the resident if unable to visualize the resident in their room prior to documenting completion of a round.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 12/20/2024 at 1:43 p.m., an interview was conducted with S3DON. She stated she was notified on 12/14/2024 sometime between 9:00 a.m. and 9:30 a.m. Resident #1 had eloped from the facility by S13RNS. She stated staff initiated a code W, which meant staff search the entire facility for the resident, and do a complete head count to ensure all other residents are accounted for, and inform Resident representative, doctors, and local law enforcement that a resident was missing. She confirmed Resident #1 eloped from the facility on 12/14/2024 at approximately 4:32 a.m. She stated on 12/18/2024 S1CADM notified her Resident #1 was located at a local gas station. At that time, Resident #1 signed the Against Medical Advice (AMA) form, and refused to return to the facility or seek medical attention. She stated nursing staff were expected to perform visual checks on the residents every two hours based on their Physician's Order. She stated staff were expected to search the facility if unable to visually observe the resident during rounds, and notify the nurse, herself, S4ADON, or S2ADM immediately.</p> <p>On 12/26/2024 at 2:10 p.m., an interview was conducted with S2ADM. S2ADM confirmed Resident #1 was missing for four days and no staff had visually observed him since 12/14/2024 at 4:00 a.m. until he was found on 12/18/2024 at 2:38 a.m. He stated he was notified by staff on 12/14/2024 around 9:00 a.m. that Resident #1 was not on the premises. He then reviewed the facility surveillance footage where Resident #1 was observed climbing over the patio fence and left the facility premises on 12/14/2024 at 4:32 a.m. S2ADM confirmed staff did not realize he was gone until approximately 8:00 a.m. S2ADM further confirmed staff failed to adequately supervise Resident #1 by not performing visual checks every two hours on Resident #1 as ordered.</p> <p>The facility had implemented the following actions to correct the deficient practice on 12/19/2024:</p> <p>1) Resident #1 left the facility against medical advice on 12/14/2024. The facility allegedly failed to effectively maintain its highest practical physical, mental, psychosocial well-being for this 1 resident by failing to ensure the resident was adequately supervised to monitor a resident who is leaving against medical advice without signing the sign-out log. All residents had the potential to be affected as the result of the alleged non-compliance.</p> <p>2) The Administrator and DON in-serviced all present nursing staff on 12/19/2024 at 6:30 p.m. The in-service included performing every 2 hour visual checks on all residents. The in-services also included the existing policy Wandering or Missing Resident that includes Code W.</p> <p>Staff unable to be in serviced on 12/19/2024 at 6:30 p.m. will not be permitted to work until they are in-serviced. All new employees will be in-serviced regarding the information listed above during their orientation period.</p> <p>A log of each resident arranged by room was implemented on 12/19/2024 to document direct observation checks every two hours on each shift. The monitor is broken into 2-hour increments and designated nursing staff are to sign off that the observations have been made. This monitoring will continue 24 hours/day 7 days/week for two weeks and then will be reviewed by the DON/designee.</p> <p>Resident patios will be monitored by a designated staff member to help ensure resident safety. Beginning at 7 p.m. on 12/19/2024, the staff will sit at the north and south smoking patio doors and go outside to monitor any resident who exits. This monitoring will continue 24 hours/day 7 days/week for two weeks and then 3 times a week for six weeks and then as needed thereafter.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Wander Data Collection Tool is completed by the MDS nurses at time of admission, quarterly, significant change in status. The tool is a scoring system indicating if a resident has a Definite Risk for elopement with a score of 3 or more YES answers, and is At Risk with a YES answer. The tally of the answers for YES is completed, and the nurse summarizes her findings on the back of the risk page which determines the most appropriate intervention accordingly, or if needed.</p> <p>On 12/20/2024, the MDS nurses began an audit of all elopement risk assessments. All residents that are identified as a risk for elopement will be discussed with the IDT in the QA meeting to determine if a plan of action is needed for those residents.</p> <p>To ensure the facility staff understand the in-service that was started on 12/19/2024, a questionnaire will be created by the Administrative Staff. Beginning on 12/20/2024, employees will complete the questionnaire to validate their understanding of the facility policy related to Wandering or Missing Resident.</p> <p>3) As of 12/19/2024, the facility has resolved the likelihood of serious harm or injury to any resident no longer exists.</p> <p>Throughout the survey from 12/19/2024 to 12/26/2024, observations, interviews, and record review revealed the above listed actions were implemented. Random staff interviews revealed staff received training on supervision, visual checks, wandering or missing residents and completed questionnaires testing their knowledge. Observations were made throughout the survey with no supervision concerns identified. Observations, interviews, and record review, revealed monitoring had begun with no further issues identified.</p>		