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AVANTE AT HARRISONBURG	94 SOUTH AVENUE HARRISONBURG, VA 22801

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{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard survey conducted 3/27/18 through 3/29/18, was conducted 5/1/18 through 5/2/18. No complaints were investigated. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. One uncorrected deficiency and two new findings are identified within this report. Corrected deficiencies are identified on the CMS 2567-B report. The census in this 117 certified bed facility was 101 at the time of the survey. The survey sample consisted of eight current Resident reviews (Residents # 101 through 108).	{F 000}	RECEIVED VDH/OLC	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656	1. Corrective action has been accomplished for the alleged deficient practice in regard to resident #102. On 5/7/18 the Elopement risk care plan was revised to include that the resident is to have one- on- one supervision at all times whenever not within the confines of the physical plant of the facility.	5/10/18

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

Jamie R. Ondeusa — LNHA — 5-10-2018

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 656	Continued From page 1 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, and staff interview, the facility failed for one of eight residents in the survey sample (Resident # 102) to develop a plan of care for supervision. Resident #102, who was identified as an elopement risk and who had an elopement, did not have a care plan to provided supervision to prevent an elopement. The findings were: Resident # 102 in the survey sample, a 76 year-old male, was admitted to the facility on 9/23/17, and readmitted on 12/31/17 with diagnoses that included cerebrovascular disease,	F 656	2. All residents have the potential to be affected by this alleged deficient practice. Steps taken to assure this does not reoccur include: 1) An Elopement Risk assessment has been completed on all current residents. Any newly identified current resident that was identified as an Elopement risk was placed in the Elopement communication book, 2) wander guard was appropriately applied and 3) care plans revised/updated as needed. For residents currently classified as Elopement Risk, placement of wander guard was validated, and care plan reviewed and updated as needed. 4) The Minimum Data Set coordinators have been re- in-serviced on developing and updating appropriate plans of care for supervision of residents that are identified/classified as at risk for elopement. 5) Receptionists and employees have been in serviced that residents with wander guards will have one-on-one supervision at all times when outside of the physical plant.	

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F 656	Continued From page 2 epilepsy, generalized muscle weakness, chronic obstructive pulmonary disease, atherosclerotic heart disease, vascular dementia, hypertension, benign prostatic hyperplasia, gastroesophageal reflux disease, dysphagia, depressive disorder, and Non-Alzheimer's dementia. According to the most recent Minimum Data Set, a Significant Change, with an Assessment Reference Date of 3/30/18, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 9 out of 15. The survey team arrived at the facility at 11:15 a.m. on 5/1/18. A male resident, later identified as Resident # 102, was on the porch, seated in a wheelchair next to the facility's front door. The resident had a Wanderguard alarm on his left ankle. At the time of the observation, a two person medical transport team was wheeling a resident into the facility. There were no staff members on the porch with the resident An Elopement Risk Assessment conducted on 1/28/18, scored Resident # 102 as a 32, with any score higher than 10 indicating an elopement risk. Review of Resident # 102's care plan, developed 10/3/17, revealed the following problem: " The resident is an elopement risk/wanderer." The goal for the problem was, "The resident's safety will be maintained through the review date." The original intervention to the stated problem was, "Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers: (sic)." On 4/25/17, the following intervention was	F 656	3. Measures put into place to ensure the alleged practice does not recur include: 1) MDS personnel or designee will audit 3 X a week for 4 weeks, than 2 X a week for 4 weeks, that all current residents as well as new admissions or readmissions identified as an Elopement Risk and are fitted with a wander guard. 2) Care plans will be audited by nursing management to validate that the resident's care plan includes the need for direct one-on-one supervision whenever they are not within the confines of the physical plant of the facility. 4. The MDS personnel will report audit findings to the QAPI committee on a monthly basis for review or recommendation and follow up for 2 months, then randomly thereafter.	

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F 656	Continued From page 3	F 656		

added, "(Name) refuses to keep wanderguard on his ankle. He keeps cutting it off when it is put back on." Another intervention, "Wanderguard per protocol. (Name) has a Wanderguard on his W/C (wheelchair) and walker," was added on 4/27/18.

During a meeting at 3:00 p.m. on 5/1/18 that included the Administrator, Director of Nursing (DON), and the survey team, the DON was asked what a score of 32 on the Elopement Risk Assessment meant. The DON indicated that the score of 32 meant Resident # 102 was "...a high risk." Asked about supervision, the DON said, "A lot of times he doesn't want someone with him."

The Administrator and DON were asked if the resident had eloped recently. The DON said that on Friday, 4/27/18, the resident went outside with a group of residents and refused to come back inside. "It took two or three people to persuade him to go back inside."

At approximately 3:20 p.m. on 5/1/18, the Administrator returned alone to the Conference Room where the survey team was meeting, and revealed that Resident # 102 had in fact left the property on 4/27/18, but that there was a staff member behind him.

At approximately 3:30 p.m. on 5/1/18, the Administrator returned to the Conference Room with RN # 1 (Registered Nurse). According to RN # 1, Resident # 102 was on the city sidewalk between the facility property and the street (South Avenue).

During a subsequent interview at approximately 9:20 a.m. on 5/2/18, the DON was again asked

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F 656	Continued From page 4 about supervision for Resident # 102 when he sits on the facility's porch. The DON reiterated her statement of the previous day that the resident, "...doesn't want someone with him." When it was pointed out that someone would not need to sit with the resident, that someone could be at the other end of the porch, the DON indicated that would still not be acceptable to the resident.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to follow professional standards of care for two of eight residents in the survey sample. 1. Nursing failed to document in the clinical record an unwitnessed fall for Resident #107. The resident's clinical record included no mention of the fall or any associated assessments or notifications to the responsible party and physician regarding the incident. 2. Nursing failed to document in the clinical record an unsafe wandering incident for Resident #102. The findings include: 1. Resident #107 was admitted to the facility on	F 658	1. Corrective action has been accomplished for the alleged deficient practice in regard to resident #107. On 5/2/18 a late entry nursing note was added to the clinical record for the unwitnessed fall. Additionally, corrective action has been accomplished for the alleged deficient practice in regard to resident #102. On 5/2/18 a late entry nursing note was added to the clinical record related to unsafe wandering.	5/10/18

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F 658	Continued From page 5 3/22/18 with diagnoses that included pneumonia, respiratory failure, dysphagia, anemia, high blood pressure and osteoporosis. The minimum data set (MDS) dated 4/19/18 assessed Resident #107 with moderately impaired cognitive skills. A list of recent falls was requested and provided by the facility after entrance on 5/1/18. This list documented Resident #107 experienced a fall on 4/27/18. Resident #107's clinical record, including interdisciplinary nursing notes, made no mention of a fall on 4/27/18. The resident's plan of care (revised 4/30/18) listed the resident fell on 4/27/18 but included no details of the incident. Nursing notes included no assessment of the resident at the time of the fall or any notifications to the physician and/or responsible party regarding the incident. On 5/2/18 at 7:40 a.m., the licensed practical nurse (LPN #1) caring for Resident #107 at the time of the fall was interviewed. LPN #1 stated the resident got out of bed around 11:00 p.m. and came to the desk asking for something to drink. LPN #1 stated the resident returned to her room and when the aide brought the drink, found the resident on the floor. LPN #1 stated she recorded the fall and her assessment of the resident on a fall incident form in the computer. LPN #1 stated there was a place in the computer system to enter a separate note but she only completed the fall incident form. LPN #1 stated she assessed the resident with no injury following the fall and promptly notified the physician and family. On 5/2/18 at 8:00 a.m., the unit manager (LPN	F 658	2. All residents have the potential to be affected by this alleged deficient practice. For all known documented resident incident/accident reports on record for the last 30 days, the resident's clinical record was audited to determine if there was nursing documentation of the incident/accident in the nurses notes section of Point Click Care. Where any voids in documentation were identified in the nurses notes section of the record, late entry updates were made. 3. Measures put in place to ensure that the alleged deficient practice does not reoccur include: 1) An in-service was completed for licensed nurses related to proper documentation in Point Click Care (PCC) when an Incident or Accident occurs and requirements to also document incident and accident notation in nurse's notes. 2) The Interdisciplinary team (IDT) will review/audit all daily reported Incidents and Accidents	

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F 658	Continued From page 6 #2) was interviewed about documentation of Resident #107's fall on 4/27/18 in the clinical record. LPN #2 stated the fall incident form completed by LPN #1 was part of their internal quality assurance documentation and was not part of the clinical record. LPN #2 stated there should have been a note about the fall entered into the record. On 5/2/18 at 8:15 a.m., LPN #2 stated again the incident form completed was not part of the clinical record. LPN #2 stated the fall and any assessments and/or notifications should be documented in the nursing notes. LPN #2 stated she was not sure if there was a written policy about documentation of falls but nurses were expected to include falls and incidents in the clinical record. The facility's policy titled Accidents and Incidents - Investigating and Reporting (revised April 2013) stated, "The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident..." This policy listed information to include on the quality assurance incident report but made no mention of documentation to include in the clinical record. The Lippincott Manual of Nursing Practice 10th edition on page 16 states regarding standards of practice, "A deviation from the protocol should be documented in the patient's chart with clear, concise statements of the nurse's decisions, actions, and reasons for the care provided, including any apparent deviation. This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events..." Page 17 of	F 658	documentation in each morning clinical meeting 5 X per week for 4 weeks, then 3 X a week for 4 weeks, to assure that accident/incident documentation is also included as notations in the nurse's clinical notes section of the medical record. 4. The Director of Nursing (DON) or designee will report on audit findings of the documentation of incident and accident against nursing notes documentation review to the QAPI committee on a monthly basis for two months for recommendation and follow up and then randomly for review and recommendations as necessary.	

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F 658	Continued From page 7	F 658		

this reference includes in a list of common departures from standards of care, "...Failure to make prompt, accurate entries in a patient's medical record..." (1)

These findings were reviewed with the administrator and director of nursing during a meeting on 5/2/18 at 9:15 a.m.

(1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014.

2. Resident # 102 in the survey sample, a 76 year-old male, was admitted to the facility on 9/23/17, and readmitted on 12/31/17 with diagnoses that included cerebrovascular disease, epilepsy, generalized muscle weakness, chronic obstructive pulmonary disease, atherosclerotic heart disease, vascular dementia, hypertension, benign prostatic hyperplasia, gastroesophageal reflux disease, dysphagia, depressive disorder, and Non-Alzheimer's dementia.

According to the most recent Minimum Data Set, a Significant Change, with an Assessment Reference Date of 3/30/18, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 9 out of 15.

The survey team arrived at the facility at 11:15 a.m. on 5/1/18. A male resident, later identified as Resident # 102, was on the porch, seated in a wheelchair next to the facility's front door. The resident had a Wanderguard alarm on his left ankle. At the time of the observation, a two person medical transport team was wheeling a resident into the facility. There were no staff members on the porch with the resident

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F 658	Continued From page 8	F 658		

An Elopement Risk Assessment, conducted on 1/28/18, scored Resident # 102 as a 32, with any score higher than 10 indicating an elopement risk.

During a meeting with the survey team at 3:00 p.m. on 5/1/18, the Administrator and Dierctor of Nursing (DON) were asked if Resident # 102 had ever left the premises while he was outside. "He will stay out 10 minutes or so and then want to come back in," the DON said. Regarding the incident on 4/27/18, the DON said the resident went out the door with a group of residents and did not want to come back inside. "It took two or three people to persuade him to come back in," the DON said. Asked if the resident had a wanderguard on at the time, the DON said that he did not. (NOTE: In a subsquent interview at approximately 9:00 a.m. on 5/2/18, the DON admitted she was not in the building at the time of the resident's elopement and was relying on what she had been told about the incident.)

At approximately 3:20 p.m. on 5/1/18, the Administrator returned alone to the Conference Room where the survey team was meeting, and revealed that Resident # 102 had in fact left the property on 4/27/18, but that there was a staff member behind him. Asked if there was an incident report of the elopement, the Administrator said there was, and she gave the survey team the report to review.

According to the report, Resident # 102 was sitting on the porch when he got up and walked across the parking lot to the street. He was seen walking down the street (sidewalk) without a wheelchair or walker. The report went on to say that two CNA's (Certified Nursing Assistants)

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F 658	Continued From page 9 caught up with the resident and after talking with him for about 20 minutes were able to bring him back to the facility. Asked why there were no Nurses Notes or other documentation of the elopement in the clinical record of the resident, the Administrator said she didn't consider the incident an elopement because Resident # 102 was "...in sight of the staff at all times." Potter-Perry notes the following regarding nursing documentation, "The record needs to describe exactly what happened to a client (resident)...Nurses need to indicate all assessments, interventions, client responses, instructions, and referrals in the medical record. (Ref. Potter-Perry Fundamentals of Nursing, 7th Edition, Chapter 26, Page 387.)	F 658		
{F 689} SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff interviews, and review of facility documentation, the facility failed for one of eight residents in the survey sample (Resident # 102) to provide supervision to prevent unsafe wandering.	{F 689}	1. Corrective action has been accomplished for the alleged deficient practice in regard to resident #102. On 5/1/18 the Elopement risk care plan was revised to include that the resident is to have one- on- one- supervision when outside of the facility physical plant and has been directly supervised one-on-one since 5/1/18.	5/10/18

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{F 689}	Continued From page 10 Resident # 102, who was identified as a wanderer and elopement risk, eloped from the facility. The findings were: Resident # 102 in the survey sample, a 76 year-old male, was admitted to the facility on 9/23/17, and readmitted on 12/31/17 with diagnoses that included cerebrovascular disease, epilepsy, generalized muscle weakness, chronic obstructive pulmonary disease, atherosclerotic heart disease, vascular dementia, hypertension, benign prostatic hyperplasia, gastroesophageal reflux disease, dysphagia, depressive disorder, and Non-Alzheimer's dementia. According to the most recent Minimum Data Set, a Significant Change, with an Assessment Reference Date of 3/30/18, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 9 out of 15. The survey team arrived at the facility at 11:15 a.m. on 5/1/18. A male resident, later identified as Resident # 102, was on the porch, seated in a wheelchair in front of a window and next to the facility's front door. The resident had a Wanderguard alarm on his left ankle. At the time of the observation, a two person medical transport team was wheeling a resident into the facility. There were no staff members on the porch with the resident An Elopement Risk Assessment, conducted on 1/28/18, scored Resident # 102 as a 32, with any score higher than 10 indicating an elopement risk.	{F 689}	2. All residents have the potential to be affected by this alleged deficient practice. Steps taken to assure this does not reoccur include: 1) An Elopement Risk assessment has been completed on all current residents. Any newly identified current resident that was identified as an Elopement risk was placed in the Elopement communication book, 2) wander guard was appropriately applied, and 3) care plans revised/updated as needed. For residents currently classified as Elopement Risk, placement of wander guard was validated, and care plan reviewed and updated as needed. 4) The MDS coordinators have been re-in-serviced on developing and updating appropriate plans of care for supervision of residents that are identified/classified as at risk for elopement. 5) Receptionists and employees have been in serviced that residents with wander guards will have one-on-one supervision at all times when outside of the physical plant.	

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(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 689}	Continued From page 11 Review of Resident # 102's care plan, developed 10/3/17, revealed the following problem: "The resident is an elopement risk/wanderer." The goal for the problem was, "The resident's safety will be maintained through the review date." The original intervention to the stated problem was, "Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers: (sic)." On 4/25/17, the following intervention was added, "(Name) refuses to keep wanderguard on his ankle. He keeps cutting it off when it is put back on." Another intervention, "Wanderguard per protocol. (Name) has a Wanderguard on his W/C (wheelchair) and walker," was added on 4/27/18. At approximately 11:45 a.m. on 5/1/18, CNA # 1 (Certified Nursing Assistant), who was providing care for Resident # 102, was asked how he gets outside. "The Receptionist knows he goes outside and she watches him from the window. I'm not sure how he gets out, but I can find out." CNA # 1 returned several minutes later and said, "The Receptionist lets him out." (NOTE: The window Resident # 102 was seated in front of is the same window where the reception desk is located.) At 11:50 a.m., the Receptionist was interviewed regarding Resident # 102. Asked how long she has worked at the facility, the Receptionist said, "About eight weeks." The Receptionist was then asked how the resident, who was wearing a Wanderguard, gets outside. "When he gets close to the door it (Wanderguard) sets off the alarm. I back up his wheelchair, reset the alarm, and then	{F 689}	3. Measures put into place to ensure the alleged practice does not recur include: 1) MDS personnel or designee will audit 3 X a week for 4 weeks, then 2 X a week for 4 weeks, that all current residents, as well as new admissions or readmissions identified as an Elopement Risk, are fitted with a wander guard. 2) Care plans will be audited by nursing management to validate that the resident's care plan includes the need for direct one-on-one supervision whenever they are not within the confines of the physical plant of the facility. 4. The MDS personnel will report audit findings to the QAPI committee on a monthly basis for review or recommendation and follow up for 2 months, then randomly thereafter.	

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	495146	A. BUILDING _____ B. WING _____	R 05/02/2018

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let him outside. He has promised not to go anywhere. I can see him through the window and I watch him like a hawk."

When asked if she had been told to let the resident out, the Receptionist said, "I have seen other people do it, so I kept on doing it too." The Receptionist then added, "I can see him from most everywhere in the lobby." Asked what happens if she has to leave the desk for some reason, the Receptionist said, "I call someone."

At the time the survey team entered the facility, a two person medical transport team was wheeling a resident into the facility. There were no staff members on the porch with the resident. When the survey team announced themselves and asked for the Administrator, the Receptionist got up from the desk, walked across the room to an office and summoned the Administrator. The office was at the far end of the lobby, and although the window at the desk was in view, there was no way of seeing anyone sitting in front of the window.

During the course of the survey, although the resident was not observed seated outside, the Receptionist was observed in a variety of activities, including signing visitors in and out of the building, answering phone calls, and accepting the delivery of packages.

At approximately 1:45 p.m. on 5/1/18, LPN # 2 (Licensed Practical Nurse), the B Wing Unit Manager, was interviewed regarding Resident # 102. Asked how the resident gets out of the building, LPN # 2 said, "I don't know how he gets out, just that he does." Asked about wandering, LPN # 2 said, "He has wandered in the parking

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lot, but he has not gotten to the road." LPN # 2 then added, "I know he was out there this morning alone. He should have someone with him, but he doesn't always."

During a meeting at 3:00 p.m. on 5/1/18 that included the Administrator, Director of Nursing (DON), and the survey team, the DON was asked what a score of 32 on the Elopement Risk Assessment meant. The DON indicated that the score of 32 meant Resident # 102 was "...a high risk." Asked about supervision, the DON said, "A lot of times he doesn't want someone with him." The Administrator and DON were also asked if Resident # 102 had ever left the premises while he was outside. "He will stay out 10 minutes or so and then want to come back in," the DON said.

Regarding an incident that occurred on 4/27/18, the DON said the resident went out the door with a group of residents and did not want to come back inside. "It took two or three people to persuade him to come back in," the DON said. Asked if the resident had a wanderguard on at the time, the DON said that he did not. (NOTE: In a subsequent interview at approximately 9:00 a.m. on 5/2/18, the DON admitted she was not in the building at the time of the resident's elopement and was relying on what she had been told about the incident.)

At approximately 3:20 p.m. on 5/1/18, the Administrator returned alone to the Conference Room where the survey team was meeting, and revealed that Resident # 102 had in fact left the property on 4/27/18, but that there was a staff member behind him. Asked if there was an incident report of the elopement, the

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Administrator said there was, and she gave the survey team the report to review.

According to the report, Resident # 102 was sitting on the porch when he got up and walked across the parking lot to the street. He was seen walking down the street (sidewalk) without a wheelchair or walker. The report went on to say that two CNA's (Certified Nursing Assistants) caught up with the resident and after talking with him for about 20 minutes were able to bring him back to the facility.

At 3:30 p.m. on 5/1/18, RN # 1 (Registered Nurse), who stated she was present on 4/27/18, said Resident # 102 "...was on the sidewalk that adjoins the property. It is city property, he was not in the street." RN # 1 also said that prior to the incident, Resident # 102 "...was already sitting on the porch."

At 8:30 a.m. on 5/2/18, LPN # 1 was interviewed regarding the incident of 4/27/18. "I was working on B Wing. He was on the porch and would not come in, so I went out (to the porch) to talk to him to get him back inside and he refused." Continuing, LPN # 1 said, "I told him to stay where he was, that I would be right back. I told the Receptionist to keep an eye on him and if he got up, to call B Wing STAT (immediately). I went back to B Wing to call his family since he does listen to them." LPN # 1 went on to say that, "When he got up, the Receptionist called B Wing. I went back out and he refused to come inside. He shook his fist at me and started walking and got to the sidewalk. Two CNA's caught up with him and were able to convince him to get in the wheelchair and return to the building."

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{F 689}	Continued From page 15 Resident # 102 was returned to the facility. He suffered no injuries during the incident.	{F 689}		