STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075299	A. BUILDING _____ B. WING _____	**09/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHELSEA PLACE CARE CENTER	**25 LORRAINE ST HARTFORD, CT 06105**

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 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 observations, clinical record review, review of facility documentation, review of facility policy, and interviews for one sampled resident (Resident #1) reviewed for elopement, the facility failed to consistently check the functionality of exit doors per the facility's practice resulting in the elopement of a conserved resident. The findings include: Resident #1's [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had little interest or pleasure in doing anything, was independent with eating, toilet use and locomotion on unit but off unit locomotion did not occur, and was on antidepressant, antipsychotic and antianxiety medications. A tour of the facility, review of the facility's alphabetical list of Residents, and review of resident records identified Resident #1 resided on the 2B unit which opened to the 2A unit. Both units were identified as closed/secured units but opened onto each other allowing residents to walk between units. Resident #1 was the only resident of the forty five (45) residents on 2A and 2B identified as using a wander guard on 8/28/20. The Resident Care Plan (RCP) dated 8/20/20 identified Resident #1 resided on a secure unit and was at risk for wandering/elopement and had a wander guard in place. Interventions directed to observe for attempts to elope and to redirect if near doors. A physician's orders [REDACTED].#1's left ankle, check for placement every shift, check for function every month, and to monitor the resident every 15-minutes on every shift. A psychiatry note dated 8/4/2020 identified Resident #1 was anxious, agitated, attempting to leave and the resident's Klonopin dose was increased. Review of Resident #1's Treatment Administration Record (TAR) dated 8/5/20 to 8/31/2020 identified documentation every shift of wander guard placement, and documentation that the monthly check for function was completed on 8/17/20. Review of the nurse's notes dated 8/4/20 to 8/28/20 identified documentation that Resident #1 displayed exit seeking behaviors of packing belongings and pacing the hallway of the unit with his/her luggage. A social service note dated 8/19/20 indicated Resident #1 had moderately impaired cognition, impaired communication and safety awareness, had history of wandering and was an elopement risk. The physician's progress note dated 8/28/2020 identified Resident #1 tried to escape from the facility. A physical exam identified that Resident #1 was awake, alert, skin was dry and intact with no rash or [MEDICAL CONDITION] and no tremors. The progress note outlined a plan to place the resident on every 15-minutes checks, continue to monitor, continue antipsychotic regimen, and psychiatry to follow-up. Interview with the Administrator on 9/1/2020 at 11:15 AM identified that camera footage was reviewed after Resident #1 eloped. The Administrator stated Resident #1 did not exit the building through the monitored doors, and the most likely exit was through the door at the end of the 2A unit. Following the elopement, the 2A unit door was checked and was identified that the alarm sounded very low and could not be heard on the unit. The Administrator stated that the battery was replaced and the alarm was back to sounding at the original volume. The Administrator identified that although there were no issues identified with any of the other doors, batteries were changed in all door alarms in the facility at that time. Interview with the Security Specialist on 9/1/20 at 11:45 AM identified that he was making rounds of the facility on 8/28/20 at approximately 1:25 PM when he observed Resident #1 outside the facility on the sidewalk by the street. The security specialist stated he redirected Resident #1 back to the facility. The security specialist identified that when he entered the main entrance with Resident #1, the resident was wearing a wander guard that triggered the alarm. He stated that when he returned Resident #1 to the unit, staff stated he was just here. The Security Specialist indicated all exits monitored by cameras were surveyed and Resident #1 was not identified as exiting the monitored doors. An interview with the Maintenance Director on 9/1/2020 at 12:00 PM indicated that all doors within the facility were checked daily to ensure their functionality. The Maintenance Director further indicated that once per month a general check up was completed to include pushing on doors to determine if hinges are loose and doors were aligned. The Maintenance Director indicated that a generator test was performed with a full load the day Resident #1 eloped (8/28/20) and may have contributed to the door malfunctioning. The Maintenance Director indicated he had been working with the facility and performing the monthly generator checks for the past 13 months and indicated there had never been an issue of the doors in the facility failing. Although the Maintenance Director stated the all doors were checked daily, he was unable to provide documentation of the daily checks. The Maintenance Director indicated that batteries were change in the door alarms 6 months prior to the door failing. The Maintenance director could not recall the exact date the batteries were last replaced and was unable to provide documentation of the dates batteries were changed prior to the replacement on 8/28/20 when the rear door to 2A unit was noted to malfunction. A review of the facility's Emergency Generator Log identified that the generator was checked on 8/28/20 between 8:30 AM and 9:15 AM. Review of an email from Facility Compliance Service identified that on 8/28/20 at 3:00 PM they received a phone call from the facility about a door magnet on the system that not working. Review of the email identified that a technician arrived on site and found all magnetic doors to be functioning properly and tested all connections. The technician was unable to duplicate a door failure in the system and indicated that all connections were good. Tour of the facility and the 2A Unit on 9/1/20 at 12:30 PM identified all door alarms were functioning. Interview with RN #2 (Nursing Supervisor 8 AM-4 PM shift) identified that she was made aware that Resident #1 left the facility after he was returned. RN #1 indicated that Resident #1 could not say when he/she left the facility but pointed in the direction of the egress door at the end of the 2A unit hallway. RN #2 stated that Resident #1 was a wonderer but there was no evidence of additional exit seeking behavior on the day the resident eloped. RN #2 further indicated she did not hear the door alarming. Interview with NA #2 on 9/1/20 at 12:55 PM identified that she cared for Resident #1 on 8/28/20. NA #2 stated that Resident #1 had his/her lunch at 1:20 PM, after which she removed the lunch tray, documented the 15-minute check at 1:30 PM, and went to care for another resident. NA #2 indicated that a few minutes later, staff was informed by the social worker that they were missing a Resident. NA #2 indicated that the Security Officer returned Resident #1 to the unit at approximately 1:45 PM. NA #2 stated that Resident #1 informed her that he/she was going to his/her son's house. NA #2 identified that she did not hear the door alarm go off and if the alarm had sounded, someone would have responded to the alarm. Interview with LPN #1 (charge Nurse 7 AM-3 PM) on 9/1/2020 at 1:00 PM identified that there were no changes in Resident #1's behavior on the day of the elopement. LPN #1 stated that the first time she was made aware that Resident #1 left the building was when the resident was returned to the unit by the Security Officer. The Security Officer reported that he found Resident #1 outside the building and returned him/her. LPN #1 stated that upon Resident #1's return to the unit, LPN #1 informed the supervisor, started an accident and incident report, completed a body audit, informed the APRN and initiated a 1:1 observation per the APRN's order. Interview with the Maintenance Assistant on 9/1/2020 at 2:00 PM identified that it was the practice of the facility to check all doors in the facility daily and indicated he was the one responsible for checking all doors in the facility. He indicated that he usually checked the doors between 7:30 AM and 8 AM daily. The Maintenance Assistant indicated that when checking exit doors, he would first check to ensure the magnets on the door worked, then he would input

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075299	A. BUILDING _____ B. WING _____	**09/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHELSEA PLACE CARE CENTER	**25 LORRAINE ST HARTFORD, CT 06105**

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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) the code in the alarm box and push the door so the alarm would go off. The Maintenance Assistant stated that on the day Resident #1 eloped(8/28/20) the doors had not been checked as he was busy in the kitchen. The Maintenance Assistant indicated he completed checks of the doors the day prior to the incident on 8/27/20 with no issues found. The Maintenance Assistant indicated he informed the Administrator that he did not complete the door checks and stated it was not the practice of the facility to keep a log of the documentation of when door checks were completed. Interview with the Administrator on 9/3/20 at 3:15 PM identified that since daily checking of the doors was a practice of the facility, she would have expected that the check was completed. The Administrator further indicated that going forward daily door checks would be documented on a checklist. Review of the manufacturers' recommendations for the alarm system used in the facility Safety Technology International EX-1STI-6400 indicated the unit runs on a 9 volt alkaline battery and since the unit was battery operated it was highly recommended that it be tested at least every 6 months to ensure that it is operating properly. Subsequent to Resident #1's elopement, the facility implemented a plan of correction to include headcount of all residents, battery were replaced on all exit alarms, and identified that batteries were to be replaced monthly going forward. Security and Maintenance staff were educated to ensure all exit alarms were audited daily, stairwell exit batteries were replaced monthly, and that daily audits of all exit alarms were to be conducted to ensure proper functioning. The facility was unable to provide an exit door/security system maintenance policy.