STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075231	A. BUILDING _____ B. WING _____	07/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APPLE REHAB COLCHESTER	36 BROADWAY STREET COLCHESTER, CT 06415

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, a review of the clinical record, staff interviews, a review of the facility policy, and a review of the facilty documentation for one sampled resident reviewed for elopement risk (Resident #1), the facilty failed to reassess elopement risk when wandering behaviors were identified and for one sampled resident (Resident #3), the facility failed to complete an accurate risk assessment and implement interventions for a resident who was at risk for elopement. The findings include: a. Resident (R) #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The elopement risk assessment dated [DATE] identified R#1 was not at risk for leaving the facilty without staff knowledge. Review of the census form dated 5/18/20 identified R#1 was moved to an alternate room located at the end of the hall near the nurse's station. The admission Minimum Data Set ((MDS) dated [DATE] identified severe cognitive impairment, extensive assistance of two persons for bed mobility, transfers and walking in room and did not walk in the hallway. Additionally, R#1 used a wheelchair for mobility, did not exhibit wandering behavior, and did not use a wander/elopement alarm. The nursing progress note dated 5/25/20 identified R#1 wanted to go home, exhibited wandering behaviors and was redirected multiple times with minimal effect. The physicians order dated 6/2/20 directed Trazadone 25 milligrams (mg) orally every 12 hours and continue Trazadone 25 mg every 6 hours as needed for anxiety and agitation. The nursing progress note dated 6/2/20 identified R#1 packed up his/her clothes and was headed down the hall in a wheelchair and new orders were received for trazadone secondary to agitation. The APRN progress note dated 6/2/20 identified R#1 continued with baseline forgetfulness, intermittent agitation and insistence on discharge from the facilty to the point of packing belongings. The nursing note dated 6/17/20 identified R#1 was wandering up and down the hall seeking exits. The nursing progress note dated 6/18/20 identified R#1 was independently moving his/her wheelchair in the parking lot and was redirected back to into the facility without injury. Review of the facilty incident report identified dated 6/18/20 at 6:30 PM identified R #1 self-propelled in a wheelchair and was found by NA #1 in the facilty parking lot close to the front door. Corrective actions included close observation of resident, the application of a wanderguard bracelet was applied, and the doors to the front lobby were to be closed, staff education was provided and and psychiatric consult was conducted. On 6/19/20 R #1 was moved to the locked dementia unit. Interview with the Director of Maintenance on 7/21/20 at 10:15 AM identified R#1 was able to push the front door open because it was not locked from the inside and the alarm does not sound unless a resident was wearing a Wanderguard bracelet. Additionally, the Director of Maintenance indicated a door alarm and keypad access code would be placed on the front door on 7/22/20 and was not done prior to this date because the electrician was busy in other facilities. Interview with the Director of Nursing Servicies (DNS) on 7/21/20 at 9:45 AM identified on 5/28/20 R#1 was moved to the end of the hall near the nurse's station away from the doors that entered the lobby so staff could watch R#1 more closely due to the resident going in and out of other residents rooms. The DNS indicated the plan was to move R#1 to the locked dementia unit as soon as a bed was available, and a bed was not available until 6/19/20. The DNS indicated she would have expected R#1 to wear a wander alarm bracelet if R#1 was an elopement risk. The DNS identified she should have completed another risk assessment when R#1 was wandering and did not. Interview with RN #1 on 7/21/20 at 1:30PM identified R#1 would propel in his/her wheelchair up and down the halls and into other residents' rooms. Additionally, RN #1 identified she never observed R#1 attempt to leave the building, however, R#1 would occasionally try to exit the double fire doors on the unit near the front lobby. RN #1 identified the double doors were closed because of COVID-19 precautions and although R#1 had wandering behavior she did not conduct an elopement risk assessment because R #1 was very confused, and she did not think R#1 would ever leave the facilty. Interview with NA #2 on 7/22/20 at 10:15 AM identified R#1 was observed in the hall propelling toward the front lobby reception area between 6:15 PM and 6:30 PM and while R#1 would wander in the hallway in his/her wheelchair, she had never noted R#1 attempt to exit the building. Interview with NA #1 on 7/22/20 at 12:35 PM identified on 6/18/20 at approximately 6:30 PM she answered the front doorbell to allow a vendor in the facilty and observed R#1 in the parking lot about 10 feet from the sidewalk. NA #1 indicated R#1 informed her she was going to the store across the street to buy cards. NA #1 identified she saw R#1 eating dinner around 5:30 PM and was not sure what time R#1 left the building. NA #1 indicated R#1 sometimes expressed that she wanted to go home. Interview with RN #2 (Nursing Supervisor) on 7/22/20 at 4:00 PM identified R#1 was found outside the front doors in the parking lot around 6:30 PM and was not injured. Additionally, RN #1 identified R#1 did not have a wandergard alarm bracelet and RN#2 did not believe R#1 was at risk for leaving the facilty without staff knowledge. Further, R#1 was able to self-propel in his/her wheelchair through the fire doors that should have been closed and exit the front door. RN #2 indicated the double doors were left open because recreation staff did not close the doors after a family window visit. Interview with the DNS on 7/23/20 at 2:30 PM identified the front door was equipped with an alarm and was locked with a coded keypad for exiting the building. b. R#3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The care plan dated 3/12/20 identified R#3 frequently wandered and was at risk for elopement with interventions that included to offer an escort for R#3 to another area of the building if observed near an exit, and offer to engage R#3 in an activity. The quarterly Minimum Data Set ((MDS) dated [DATE] identified severe cognitive impairment and the resident did not wander. Additionally, R#3 required supervision for transfers and when walking in his/her room or hallway, and used a walker. The elopement risk assessment form dated 5/19/20 identified R#3 was not mobile and the elopement risk asessment was not completed because the assessment directed no further evaluation was necessary if R#3 was not mobile with or without an assistive device. Physicians orders dated 5/27/20 identified R#3 could walk in the hallway with modified independence. The care plan dated 7/21/20 identified R#3 was at risk for elopement from the facilty and interventions included to check R#3's whereabouts every 15minutes until a wandergard was applied. The elopement risk assessment dated [DATE], identified R# 3 was mobile with an assistive device, repetitively expressed wishes to go home and was at risk for elopement from the facilty. Additionally, 2 of the 8 questions had a yes response. The elopement risk form identified if the assessor answered yes to any questions, the resident was at risk for elopement and instructed to institute the use of wander gard elopement device. Interview with the DNS on 7/21/20 at 12:00 PM identified R#3 was at risk for elopement because he/she could walk and expressed wishes to go home. Additionally, the DNS indicated RN #3 did not complete the elopement assessment form on 5/19/20 correctly because R#3 was mobile and could walk in the hallway. Further, the DNS indicated a complete elopement evaluation should have been conducted and it was not. RN #3 did not know why she complete the form inaccurately and the DNS indicated she provided education to RN #3. Interview with RN # 3 on 7/27/20 at 2:35 PM identified she did not complete the elopement risk assessment accurately on 5/19/20 and indicated she clicked the wrong button when answering the assessment questions. Additionally, RN #1 identiifed R#3 did walk about the facitly with a walker and often expressed wanting to leave, however RN #3 did not see R#3 make attempts to leave the facilty. Review of the facilty policy entitled Elopment Assessment directed in part that the purpose of the policy was

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) to identify all residents who were at risk for elopement and institute interventions for those residents at risk. Additionally, all resident would be evaluated on admission, readmission, quarterly and with a change in condition using the elopement risk evaluation. The policy further directed that a care plan would be developed, and interventions would be implemented. If a resident was identified at risk, a Wander Gard bracelet would be placed on the resident's wrist or ankle.