STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075314	A. BUILDING _____ B. WING _____	**06/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TOUCHPOINTS AT MANCHESTER	**333 BIDWELL ST BOX 1296 MANCHESTER, CT 06040**

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 facilty documentation and staff interviews for 1 of 3 residents reviewed for elopement (Resident #1), the facilty failed to ensure measures were in place to prevent an unauthorized leave of absence for a resident on a locked behavioral health unit. The findings include: Resident (R) # 1 was admitted to the facilty on 2/25/19 with [DIAGNOSES REDACTED]. Physician's orders dated 3/16/20 directed R #1 may go on out trips with the recreation staff. The quarterly Minimum Data Set ((MDS) dated [DATE] identified intact cognition, the resident could make him/herself understood, understands others and had not exhibited wandering behavior. Additionally, R #1 could wash, dress, toilet, transfer and eat by him/herself with a set up, and could walk independently. The care plan dated 5/13/20 identified a problem of altered thought processes related to a psychiatric [DIAGNOSES REDACTED].#1 refused to take medications, exhibited paranoid and delusional behaviors, and participated in a recovery focused behavioral health program on a secured unit. Interventions included to educate R #1 on unit guidelines and conduct a regular safety status review. The Behavioral Health Program Individualized Assessment of Resident Safety Status dated 5/20/20 identified R #1 was not a significant risk for an unauthorized leave from the facilty. Review of the behavior intervention monthly flow sheet for June 2020 identified R #1 refused medications daily and exhibited delusions. Review of the nurse's notes dated 6/10/20 at 8:15 AM identified R #1 was missing from the unit, the administrator was notified and a search was initiated. R # 1 was observed walking back to the facilty by a staff member and was escorted back. R #1 was placed on 1:1 observation and sent to the emergency room for an evaluation on 6/10/20 at 4:30 PM. Review of the emergency room disposition report dated 6/10/20 identified R #1 had a medical workup and no acute abnormalities were identified. R #1 was discharged back to the facilty. Review of a facilty licensing and investigation reportable event form summary dated 6/10/20 at 8:15 AM identified R#1 was not observed in his/her room or on the unit. Staff members searched the inside and outside of the facility and were unable to locate the resident. The conservator of person, physician and police were notified, and an organized search was conducted. The report further identified R #1 was observed walking back to the facilty at 3:30 PM and was escorted back to the facilty with shopping bags by a staff member. Additionally, R #1 told the staff he/she was at work. The report indicated R #1 left the facilty by pushing the release button behind the nurse's station to unlock the secured unit door and was able to leave through the front door as the lock disengaged at 5:00 AM. Review of the facilty plan of correction dated 6/10/20 directed immediate interventions that included the secured unit release button was removed, key pad codes were changed, all doors were checked by the maintenance department, the front door was locked and would remain locked unless monitored by a staff member. Physician's orders directed 1:1 observation on 6/10/20 and then every 15-minute checks on 6/11/20, education was provided on elopement to all staff members, and other residents were reviewed for elopement. Review of the Behavioral Health note written by APRN #1 on 6/11/20 identified R #1 had a recent elopement from the facilty for work and had not shown previous exit seeking behaviors or the desire to leave the facilty. The note further identified R #1 had delusions and refused medications. APRN #1 encouraged R #1 to take medication. Observation of the nurse's station and interview with the Director of Nursing (DON) on 6/15/20 at 9:30 AM identified the door release button was removed at the the nurse's station that allowed the staff to let visitor's and vendors off the unit without the need to use the keypad on the door. Additionally, staff would watch the mirror on the wall across from the nurse's station to ensure residents did not leave the unit when the door opened. The DON identified the door opened and closed within 10 seconds and indicated the release button had been used for over [AGE] years and she did not know why it was installed. The DON concluded from her investigation that R #1 pushed the button and walked out of the unit door and was able to walk out the front door as it automatically unlocked at 5:00 AM so the lab and other vendors can get out of the facilty without staff assistance.The DON indicated the release button was removed immediately, and the front door to the facility would be locked from 8:00 PM until 8:00 AM, at which time the receptionist would monitor the entrance door. Interview with The Director of the Behavioral Health unit on 6/15/20 at 9:35 AM identified R #1 did not exhibit exit seeking behavior prior to this incident. R#1 told her he/she hit the button at the nurse's station and went out the front door. Additionally, R # 1 indicated he/she took the bus to a nearby town and went shopping. Review of the facilty security video camera footage on 6/15/20 at 10:35 AM identified on 6/10/20 at 5:31:51 AM R #1 walked out of the facility via the front door, and across the driveway, wearing jeans, a black sweatshirt and had a purse over his/her shoulder. Interview with R #1 on 6/15/20 at 10:15 AM identified he/she left the facilty on 6/10/20 to go to work. Additionally, R #1 indicated she worked for the state and the governor had given her a directive to leave the facility. Furthermore, R #1 identified he/she pushed the button at the nurse's station, walked out of two doors and went to work. Interview with the Maintenance Director on 6/15/20 at 11:00 AM identified the automatic door release button behind the nurse's station was in place for years and he did not know why. Additionally, he indicated the release button may have been used in place of the keypad on the door, so the facility staff did not have to get up and leave the nurses station. Additionally, the Maintenance Director identified the button was removed immediately after the incident. Interview with LPN # 1 on 6/17/20 at 9:38 AM identified she did not know R #1 left the building on 6/10/20. LPN #1 indicated she last saw R #1 at approximately 5:30 AM when she administered medication to him/her. LPN # 1 identified R #1 had never attempted to leave the facility. LPN #1 identified NA #1 was providing care to other residents at 5:30 AM and LPN #1 was passing medications. Furthermore, LPN #1 identified the buzzer behind the nurse's station was used to let visitors or other staff off the unit and did not require a code. Review of the facility policy entitled Unauthorized Leave from the facility identified all residents who have been determined to be capable of meeting their minimal basic needs would be evaluated for an unauthorized leave as part of their capacity to meet minimal basic needs. A care plan would be developed if the resident was assessed for unauthorized leave.

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.