| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075196 | A. BUILDING _____ B. WING _____ | 06/08/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| HARBOR VILLAGE NORTH HEALTH AND REHABILITATION CEN | 78 VIETS ST EXTENSION NEW LONDON, CT 06320 |

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<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on a review of clinical records, reportable events, staff interviews and policy review for one of three sampled residents identified to be at risk for elopement (Resident #1), the facility failed to provide the necessary supervision to protect the resident who subsequently left the building without the knowledge of staff and was found by the police on a busy street more than one quarter mile from the nursing home. The facility further failed to ensure that the resident's location in the building was monitored every fifteen minutes in accordance with the physician's orders and also failed to ensure that an outdoor search was immediately initiated when a wanderguard door alarm and exterior door alarm sounded or that the necessary procedure was implemented to determine if a resident was missing, resulting in a finding of immediate jeopardy. Immediate jeopardy was abated on 6/5/20 when the facility implemented an action plan to mitigate risk which was verified on 6/6/20. The finding includes: Resident #1 was admitted to the facility from the hospital on [DATE] with [DIAGNOSES REDACTED]. A nursing admission assessment dated [DATE] indicated the resident was independent with activities of daily living (ADL), ambulated independently and was not at risk for elopement. An admission history and physical dated 5/27/20 identified that the resident had been hospitalized after experiencing a [MEDICAL CONDITION] indicated the hospitalization was complicated by the resident's impulsive behaviors and frequent falls. The admission history and physical further identified that during the hospital stay the patient was seen by psychiatry due to the behaviors and was started on [MEDICATION NAME] 250 milligrams every eight hours and [MEDICATION NAME] 0.5 milligrams twice daily. The note<br>further identified the resident's mood and affect were stable. Review of a psychiatry note dated 5/28/20 identified the resident's judgment, insight, mood and affect were impaired. The note identified the resident demonstrated impulsivity and disorganization, had no evidence of [MEDICAL CONDITION] and indicated that [MEDICATION NAME] would be discontinued with<br>Trazadone 25 milligrams started every six (6) hours as needed for anxiety and agitation. A physician's progress note dated 5/29/20 indicated the resident continued to be impulsive and would be followed by psychiatry services. On 6/3/20 at 2:49 PM a nurse's note identified that the resident was upset and had attempted to leave through a back door. The note indicated that an elopement evaluation had been completed, and the resident was provided with a wanderguard device on the right wrist. A subsequent nurse's note dated 6/3/20 at 9:25 PM identified that the resident persisted in attempting to exit the building, and the wanderguard device was in place and active. The nurse's note further indicated that the resident had been moved to a room closer to the nurse's station and was placed on every fifteen minute checks. Review of a reportable event dated 6/5/20 at 6:45 PM identified Resident #1 had eloped from the facility. The documentation indicated that the resident was last seen at approximately 6:30 PM when Nurse Aide #3 provided assistance to the resident. The report identified that when alarms sounded on an outside door at 6:40 PM, the charge nurse (Licensed Practical Nurse #1) instructed Nurse Aide #1 to check the doors as the nurse was leaving for a meal break. The report further noted that LPN #1 received a call from the police station at 6:55 PM on 6/5/20 indicating that Resident #1 had been observed on a main street approximately one quarter mile from the facility. The resident was subsequently returned to the nursing home by emergency medical services on 6/5/20 between 7:15 PM and 7:20 PM. On 6/5/20 at 11:48 PM a nurse's note which was written by Nursing Supervisor #2 identified that at approximately 6:45 PM the facility had received a call from the local police department reporting that the resident had been found by the police. The note indicated that after returning to the nursing home, the resident was assessed and found without injuries. The note further identified the physician had been informed and directed the facility to provide the resident with one-to-one supervision until an evaluation was performed by psychiatry services. Although a monitoring tool that was initiated on 6/3/20 due to Resident #1's exit seeking behaviors identified that the resident's location and activity were to be checked every fifteen minutes, documentation failed to identify that any checks had been completed regarding the resident's location or activity on 6/5/20 from 3:15 PM to 6:45 PM when the resident was located by the police. Another monitoring sheet which was completed by the charge nurse indicated that Resident #1 was in his/her room on 6/5/20 throughout the period from 6:00 PM through 8:00 PM. Interview with the Director of Nursing (DON) on 6/6/20 at 10:10 AM identified she had received a call from the evening supervisor on 6/5/20 stating that Resident #1 had eloped and was found a distance away from the facility. The DON stated LPN #1 reported that when the door alarm sounded on 6/5/20 at approximately 6:40 PM, she was starting to leave for a meal break and instructed Nurse Aide #1 to check the door. The DON stated NA #1 was assigned to Resident #1 for the 3:00 PM to 11:00 PM shift on 6/5/20. The DON indicated NA #1 told her that she went to the doors, heard both the wanderguard alarm and an alarm on the exterior doors sounding and shut off the alarms. NA #1 further relayed when she saw that the outside door was ajar, she closed the door and returned to work without informing the nurse about her observations. Interview with NA #1 on 6/6/20 at 11:45 AM indicated that when she reached the two sets of doors where the alarms were sounding, she did not know the wanderguard alarm was sounding, and she entered a code to deactivate the alarm. NA #1 further stated that after continuing to hear an alarm, she saw the outside exterior door was ajar, looked outside without seeing anyone, closed the door and turned off the alarm, returning to work. NA #1 stated that she had received education regarding how to respond if the wanderguard system and the exterior door alarms sounded although she did not provide an explanation about why she had failed to inform the charge nurse or supervisor that she had not seen anyone when she looked outside after turning off the alarms. NA #1 stated that she was not familiar with Resident #1. NA #1 indicated that when she arrived on the floor to report for duty after the start of the shift, she did not ask a nurse about the needs of Resident #1 and could not recall that anyone provided information to her regarding the resident. NA #1 indicated she did not know the resident required every fifteen minute monitoring. Interview with LPN #1 on 6/6/20 at 12:00 Noon indicated that when she was starting to leave for a meal break on 6/5/20 at approximately 6:40 PM, an alarm on a back door sounded. LPN#1 stated that she directed NA #1 to check the door, and the alarm subsequently stopped sounding. LPN #1 further stated that while she remained on the break, the police called to report that a resident who was wearing a johnny coat and gripper socks had been found wandering on a main street which was a distance from the facility. LPN #1 indicated that when the door alarm was sounding, she did not consider the need to check to see if all residents could be located as staff have often gone through the rear door. LPN #1 noted that she had last seen Resident #1 at approximately 6:15 PM before leaving for a break. LPN #1 further identified that the resident required every fifteen minute checks, and both the nurse and nurse aide are responsible to check on the resident every fifteen minutes and document the checks on the resident monitoring tools. LPN #1 stated that she signed the resident monitoring tool ahead of time because the resident had been in his/her room when she made observations. Interview with the Director of Maintenance on 6/8/20 at 12:30 PM identified that during all staff orientation and annually, staff are educated on the wanderguard system and the exterior door alarms. The Maintenance Director stated that if an alarm sounds, staff are directed to check the area and if no one is observed, staff are expected to immediately report the incident to the nursing supervisor. Interview with RN |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **075196** | A. BUILDING _____ B. WING _____ | **06/08/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **HARBOR VILLAGE NORTH HEALTH AND REHABILITATION CEN** | **78 VIETS ST EXTENSION NEW LONDON, CT 06320** |

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<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 1)<br>Supervisor #2 on 6/8/20 at 12:35 PM identified that at the start of the shift on 6/5/20 she went to Resident #1's unit and gave report to all staff including LPN #1 and NA #1 regarding the resident's risk for elopement, the need for every fifteen minute checks as well as instructions to keep an eye on the resident. RN Supervisor #2 stated that when Resident #1 returned, he/she was dressed in a johnny and pants and was wearing gripper socks. She identified that she assessed the resident to have no injuries, notified the physician and placed the resident on one to one supervision. RN Supervisor #2 stated that after the incident, she spoke to staff and was told the wanderguard and door alarms had sounded earlier and had been turned off by NA #1 who did not inform her that the alarm was sounding. RN Supervisor #2 stated that if she had known about the incident, she would have immediately conducted a census count to ensure all residents were located. Interview with NA #2 on 6/8/20 at 2:05 PM indicated that NA #1, who was assigned to Resident #1 during the second shift on 6/5/20, would be responsible for conducting every fifteen minute checks. NA # 2 stated that the last time she saw the resident was at approximately 6:00 PM on 6/5/20 when she retrieved Resident #1's dinner tray. Interview with NA #3 on 6/8/20 at 2:30 PM indicated she last saw the resident around 6:30 PM on 6/5/20 as she walked by the resident's room and noticed that water had spilled on the resident. NA # 3 stated that she helped the resident change the pants and left the room afterward. Interview with the Director of Nursing on 6/8/20 at 1:00 PM identified that if door alarms sound, staff are to respond to the alarm, check the area for residents and if the staff do not see anyone, they are expected to report to the nurse immediately so that the supervisor can be made aware and a head count can be completed. The DON stated if a resident is not accounted for, a search would be started to locate the resident. Review of facility documentation dated 6/5/20 with the Director of Nursing on 6/8/20 identified that staff education was initiated during the evening of 6/5/20 and included the procedure for responding to door alarms as well as door security, all residents identified to be at risk for elopement/wandering were assessed for wanderguard placement and functioning, and all facility door alarms and wander guard alarms were tested for function. All staff were educated prior to working their next shift. Review of the facility policy entitled, Door Security, identified that it is the facility's standard to minimize safety risks to residents through the use of specialty alarms and locking devices on each nursing exit door. The policy identified that it is everyone's responsiblity to respond immediately to door alarms, and it is necessary for an incident that relates to an elopement to be reported immediately to a nursing supervisor. Although the facility was unable to provide a policy regarding the use of the resident monitoring tools, the Director of Nursing stated that the assigned nurse aide is responsible for conducting and documenting every fifteen minutes checks, and the charge nurse is responsible for ensuring that the monitoring of the resident is completed. |