STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335322	A. BUILDING _____ B. WING _____	08/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HORNELL GARDENS, L L C	**434 MONROE AVENUE HORNELL, NY 14843**

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 interviews and record reviews conducted during an Abbreviated Survey (complaint #NY 108) completed on 8/6/20, it was determined that for two of three residents reviewed, the facility did not ensure that the residents received adequate supervision to prevent potential accidents. Specifically, the staff did not recognize that when the fire alarm sounded the doors unlocked, Resident #1 left the building undetected, and Resident #2 was found in the stairwell. This is evidenced by the following: The Director of Maintenance provided a copy of the undated Policy and Procedure for Responding to a Door Alarm on 7/30/20 at 1:55 p.m. which included: Remember when the fire alarm sounds the door magnets release. All doors must be monitored by staff to prevent elopement until the system is reset. The Registered Nurse (RN) Supervisor, when interviewed by telephone on 7/31/20 at 12:15 p.m., said that the power flickered and the fire alarm sounded at 5:30 p.m. on 7/6/20. 1. Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) Assessment, dated 6/17/20, revealed that the resident had severely impaired cognition and did not have any wandering behavior. The Elopement Risk Assessment, updated 6/10/20, revealed that the resident no longer had exit seeking behavior and was no longer an elopement risk. The resident's wanderguard was removed. The Comprehensive Care Plan, dated as reviewed 6/27/20, and the Certified Nursing Assistant Resident Care Plan, dated 7/12/20, did not include interventions for wandering or risk of elopement. An Integrated Progress Note, dated 7/6/20 at 5:45 p.m., documented that the resident was in their wheelchair and was found in the stairwell after the power surge. The Report of Incident or Accident, dated 7/6/20, revealed that the power outage caused the doors to unlock. The resident was able to open the stairwell door and get into the stairwell in their wheelchair. The Registered Nurse (RN) Supervisor documented that during the power outage, the resident was able to get the door open to the B hall stairwell. Staff were passing trays and were unable to find the resident. A search of the facility found the resident locked in the stairwell. When interviewed on 7/31/20 at 11:05 a.m. via telephone, Certified Nursing Assistant (CNA) #1 said that the power went out around dinnertime. She said staff went through and checked doors and windows. She said it was reported that Resident #2 could not be located. CNA #1 stated that the resident had been sitting by the stairwell door in their wheelchair when dinner trays were being served. CNA #1 said that staff were watching the residents, but nobody was standing at the exit doors. CNA #1 said after the resident was found in the stairwell, the alarms were reset and staff did not think anyone else could exit. When interviewed on 7/31/20 at 12:15 p.m., the RN Supervisor said staff noticed that Resident #2 was missing when the Unit Secretary entered their room to pass their dinner tray. The RN Supervisor said she instructed staff to get a total head count of residents. She said Resident #2 was found in the stairwell the second time that it was checked through the window. 2. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS Assessment, dated 5/22/20, revealed that the resident had severely impaired cognition and exhibited wandering behavior on four of six days. The Elopement Risk Assessment, updated 5/23/20, scored the resident at high risk for elopement and documented that a wanderguard was applied. The Comprehensive Care Plan, dated 8/26/19, revealed the resident was a high risk for elopement due to advanced dementia. Interventions included: to ensure the resident's wanderguard was in place, observe the resident for exit seeking behaviors, and the resident has increased wandering or exit seeking behaviors during times of increased anxiety or confusion. The Certified Nursing Assistant Resident Care Plan, dated 7/12/20, revealed that the resident was at risk for elopement and had a wanderguard on their left ankle. An Integrated Progress Note, dated 7/6/20 (6:25 p.m.), revealed that the resident was seen outside the facility. Staff ran outside, found the resident, and brought them back inside the facility. The Report of Incident or Accident, dated 7/6/20 at 6:25 p.m., documented that the resident was able to get outside the facility. The resident was seen by staff and brought back inside the facility. The attached Incident Investigation Form documented that the resident was able to get outside from the door at the end of the B hall after the power went out as the door alarms were not functioning properly. The resident wanders and was always looking for their parents and family. When interviewed on 7/30/20 at 1:15 p.m., the Licensed Practical Nurse said the resident was always exit seeking and tried to leave daily. She said the resident cannot get out because the doors are locked and alarmed. In an interview on 7/30/20 at 1:55 p.m., the Director of Maintenance said the directions for resetting the alarm were posted next to the alarm panel and had been there for years When interviewed on 7/31/20 at 12:15 p.m. via telephone, the RN Supervisor who worked the evening of 7/6/20, said that at approximately 5:30 p.m. the power flickered, and the fire alarm sounded. The RN Supervisor stated that while she was attempting to reset the alarm, staff continued to pass dinner trays and monitored residents who remained in the hallway. The RN Supervisor stated that she did not know the doors unlocked when the fire alarmed sounded. She said nobody realized that the doors were unlocked. The RN Supervisor stated that when staff were picking up dinner trays in resident rooms, a staff member saw Resident #1 outside of the building. At that time, she instructed staff to get a total head count and to check all the doors. She said the door at the end of the B hall was found unlocked. The RN Supervisor stated that the door had been locked when it was first checked. The RN Supervisor stated to unlock the door at the end of the B hall, a code would need to be entered and the green button on the wall would need to be pushed. The RN Supervisor said that after Resident #1 was returned to the building, she instructed staff to stand at the door and the Director of Maintenance and the Director of Nursing were called. When interviewed on 7/31/20 at 2:00p.m, CNA #2 stated that prior to the 7/6/20 incidents she was not aware that when the fire alarm sounded the doors unlocked. When interviewed via telephone on 7/30/20 at 1:50 p.m. and on 8/6/20 at 2:30 p.m., the Director of Nursing said the staff should have known to supervise the doors when the power went out and the fire alarm sounded. She said the facility does not have any evidence that staff were educated regarding the alarm system. (10 NYCRR 415.12(h)(2))

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.