STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075320	A. BUILDING _____ B. WING _____	07/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST CAMILLUS REHABILITATION & NURSING CENTER	494 ELM ST STAMFORD, CT 06902

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 resident, (Resident #1) reviewed for accidents, the facility failed to ensure timely notification when the resident, who was on enhanced supervision monitoring, was discovered missing. The findings include: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly MDS assessment dated [DATE] identified Resident #1 had severely impaired cognition, was independent with supervision for walking, utilized a cane and did not exhibit wandering behavior. The care plan dated 6/20/20 identified Resident #1 was at risk for elopement related to one or more attempts to leave the facility at this facility and other facilities, cognitive loss and dementia. Interventions included to utilize a Wanderguard attached to the left ankle, checking the function daily during the night shift, maintain a photo at the front desk reception area and diverting the Resident by giving alternate objects or activities. An Elopement Evaluation dated 6/30/20 identified Resident #1 was able to walk, had a [DIAGNOSES REDACTED]. The care plan is adjusted for residents identified at risk. Review of the15 Minute Check Monitoring Roster dated 7/4/20 reflected Resident #1's whereabouts were checked every 15 minutes between 8:00 AM and 7:45 PM. A Nursing Progress Note dated 7/4/20 at 8:49 PM identified Resident #1 was not in his/her room during a room check, the supervisor was made aware and the facility policy for missing person was activated, including a search of the entire building and premises. Additionally, Resident's #1's representative was made aware, and the local police were notified. A Risk Management System (RMS) form dated 7/4/20 at 11:31AM identified the nursing staff was alerted that Resident #1 was missing. The assigned nurse, LPN #2, identified s/he last saw Resident #1 around 8:00 PM on an alternate hallway with another male and female resident. When LPN #2 went to check on Resident #1 again, the Resident was not in the hall or in his/her room, and a search was initiated. The facility's missing person protocol included calling (Dr. Hunt) overhead three times, checking nearby rooms and bathrooms were searched, the entire building and outside premises. Police, Administrator, DNS, physician and family were notified. At 11:55 PM Resident #1 was escorted back to the facility by police. A Reportable Event Form dated 7/5/20 at12:46 PM identified Resident #1 had a history of [REDACTED]. On 7/4/20 at 8:00 PM, Resident #1 was last identified to be seen in the facility. All areas were searched, police, physician and family were notified. Resident #1 was found 2.9 miles away in a residential area and was returned to the facility by police on 7/4/20 at 11:55 PM. Resident #1 had no injuries noted and the Wanderguard was in place and functioning upon the Resident's return. Resident #1 denied pain and a skin assessment was completed upon return. Resident #1 was placed on 1:1 monitoring until a facility investigation was completed. A statement dated 7/5/20 written by LPN #2 identified s/he was the assigned nurse for the 3:00-11:00PM shift on 7/4/20. LPN #2 indicated s/he observed Resident #1 talking with other residents on a separate wing of the secured unit on the second floor and obtained his/her vital signs at 8:00PM. Resident #1 asked how s/he could get back to his/her room and LPN #2 directed Resident #1 down the hall back to his room. LPN #2 indicated when s/he went to give Resident #1 his/her medications at 9:00PM, the Resident was discovered missing. LPN #2 identified checking Resident #1's usual spots on the unit and could not locate him/her. Interview with the Administrator on 7/7/20 at 10:50 AM identified she received a call on 7/4/20 at approximately 10:00 PM that Resident #1 was missing, and that staff completed a room/building/ premise search and were driving the streets to search for the missing resident. The Administrator indicated the facility protocol for a missing resident was activated and all parties had been notified. According to the Administrator, LPN #2 administered Resident #1 his/her medications and obtained vital signs at 8:00 PM that night. The assigned nurse's aide, NA #1, indicated she had last seen the resident around dinner time (dinner determined to be at 5:10PM by video surveillance). Resident #1 was found by police at 11:55 PM, fully clothed and brought back to the facility. An assessment was completed and there were no injuries. Resident #1 was placed on 1:1 supervision and on observation for Covid 19 due to unknown exposure during the elopement. The Administrator indicated the facility had surveillance cameras which identified at 6:07PM, Resident #1 was observed walking back and forth from his room to the nurse's station. LPN #1 was seen responding to a door alarm around dinner time at the end of the hallway on the 2nd floor. According to the Administrator, LPN #1 looked down the stairway and didn't see anyone, nor was the resident seen at the door by LPN #1, and she reset the alarm. The facility did not realize Resident #1 was missing until after 9:00 PM. The Administrator indicated the investigation was still in progress and that while Resident #1 had wandering behaviors, he/she had not demonstrated any exit seeking behaviors for a year. Review of the Q15 Minute Check (every)Monitoring Roster dated 7/4/20 identified Resident #1's whereabouts were checked every 15 minutes between 8:00 AM and 7:45 PM. Review of the electronic video surveillance of the secure dementia unit located on the second floor of the facility, dated 7/4/20 from 6:00 PM to 9:45 PM identified the following; Between 5:20PM-5:28PM, Resident #1 observed walking up and down the hall with the assist of a cane. At 5:28PM NA#1 observed going into Resident #1's room with a meal tray. At 5:40PM Resident #1 observed walking up the all towards the nurse's station. Between 5:42PM-5:49PM LPN #2 observed taking resident #1 vital signs and administering medications. At 5:51PM, Resident #1 was observed heading back to his/her room. At 5:58PM, Resident #1 walked up the hall towards the nurse's station. At 5:59PM Resident observed walking onto a separate unit momentarily, then turn around and head towards his/her room. No other residents were observed in the area. At 6:03 PM, Resident #1 was seen walking up and down the hall between the nurse's station and his/her room at the end of the hallway, which was adjacent to the fire door, which lead to a stairway At 6:04PM Resident #1 was again observed walking up the hallway and enter onto an alternate unit. No other residents were observed in the area. At 6:05 Resident #1 was observed leaving the alternate unit with LPN #2. At 6:07 PM, LPN #2 was observed gesturing (no audio) to Resident #1, and pointing down towards the resident's room, and Resident #1 walked into his/her room. At 6:08 PM, Resident #1 was observed at the fire door next to his/her room. NA #2 approached the door and Resident #1 went back to his/her room. At 6:09 PM, Resident #1 was observed in front of the fire door. The electronic video monitoring skipped from 6:09PM - 6:12 PM and Resident #1 was no longer viewed on the screen. At 6:13 PM, LPN #1 was observed walking down towards the fire door where the visual at the end was unknown. Resident #1 was not seen on video surveillance after 6:09 PM on 7/4/20. At 6:47 PM, NA#1 was observed going to the entryway of Resident #1's room, then headed back up the hall. At 7:26 PM, LPN #2 was observed going down to Resident #1's room with the medication cart, used the phone in the middle of the hallway, and then walk to the nurse station to use the phone at the front desk. At 7:38 PM, RN #2 is observed entering onto secure dementia unit located on the second floor of the facility but then exits. At 9:39 PM, multiple staff are observed walking in and out of rooms secure dementia unit located on the second floor of the facility. Interview with NA #1 on 7/7/20 at 2:00 PM, and 7/8/20 at 10:15 AM identified she was assigned to Resident #1 during the 3:00 PM - 11:00 PM shift and was responsible for the every 15 minute enhanced supervision monitoring. NA #1 identified staff must physically verify that a resident is present when placed on every15 minute enhance monitoring. NA #1 identified Resident #1 was observed periodically in the hallway up until what she believed

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) to be approximately 7:45 PM and based the 15 Minute Check Monitoring Roster dated 7/4/20. NA #1 identified although s/he was observed on video surveillance walking to the entryway of Resident #1's room at 6:47 PM, s/he identified s/he was looking for the Resident's roommate and did not actually look to see if Resident #1 was in the room. NA #1 further identified while s/he was not observed to have physically been verifying Resident #1's location on the second floor secured unit by video surveillance unit between 6:00 PM and 7:45 PM as documented on the Q15 Minute Check (every)Monitoring Roster dated 7/4/20, as s/he was unsure of the time and never looked at his/her watch as there was no time to do so. S/he identified perhaps something was wrong with the video camera or perhaps s/he had made a mistake. An interview with LPN #2 on 7/7/20 at 3:02 PM identified s/he was the assigned nurse for Resident #1 on 7/4/20 during the 3:00 PM -11:00 PM shift. LPN #2 indicted she obtained vital signs and administered medications at around 5:00 PM to Resident #1(in direct conflict with his/her statement which noted vital signs were obtained at 8:00PM). Video surveillance identified Resident #1's vital signs and medications were obtained between 5:42PM and 5:49PM. LPN #2 believed she had seen Resident #1 at 8:00 PM and redirected the resident back to his/her room for medications. This is in direct conflict with video surveillance that showed Resident #1 being redirected back to his room by LPN #2 between 6:04PM and 6:07PM when LPN #2 was observed gesturing to Resident #1, and pointing down towards the resident's room, LPN #2 indicated s/he did not administer medications to Resident #1 at 8:00 PM and had forgotten to indicate on the MAR indicated [REDACTED]. This is in direct conflict with LPN #2's written statement indicating s/he last saw resident #1 at 8:00PM and later to administer medications at 9:00PM. LPN #2 indicated she was not aware the resident was missing until sometime after 9:00 PM. But in an amended written statement dated 7/7/20 where LPN #2 indicated s/he went to give Resident #1 his medications, that s/he was not in his/her room, so s/he did not administer the medications. Video surveillance noted LPN #2 was observed in front of Resident #1's room with his/her medication cart at 7:26PM. Video surveillance also identified Resident #1 was not observed on any hallway on the unit after 6:09PM. The Administrator directed LPN #2 to amend his/her statement on his/her next scheduled day to the conflict in times of what was previously reported. Attempts to reach LPN #2 for additional information was unsuccessful. An interview with RN #2 on 7/7/20 at 4:08 PM and 7/9/20 at 10:00AM identified LPN #2 went to give Resident #1 his/her 9:00 PM medications and discovered the resident was not there. RN #2 indicated s/he was not notified until 9:30 PM, at which point s/he activated the policy for a missing resident and notified the Administrator and DNS. The policy for an Elopement of a Patient dated 5/15/20 notes elopement occurs when a resident leaves the premises without authorization. For any unwitnessed elopement, staff are to search room to room and all areas of the center as well as the outside perimeter and grounds. If the patient is not found, law enforcement, nurse supervisor, Center Executive Director (Administrator) and Center Nurse Executive (DNS) is notified. All staff are to be trained on the center's door security system and required response to the sounding alarm. The policy further directs staff witnessing a confused patient or identified elopement risk patient attempting to leave the center, will intervene as appropriate to redirect the patient to a safe area and prevent elopement. The facility failed to ensure timely notification when a resident on enhanced supervision monitoring was discovered missing.
F 0689 **Level of harm** - Immediate jeopardy **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 observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 5 sampled residents, (Resident #1) reviewed for accidents, the facility failed to implement adequate supervision for a resident known to wander and/ or exhibit exit seeking behaviors, who was on enhanced monitoring to prevent an elopement, failed to ensure all staff were trained on the door security system, which resulted in Immediate Jeopardy when Resident #1 was able to exit the facility through two alarmed door, missing for approximately 5 hours and traveled 2.9 miles from the facility. The finding includes: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #1 resided on a secure dementia unit located on the second floor of the facility. The quarterly MDS assessment dated [DATE] identified Resident #1 had severely impaired cognition, was independent with supervision for walking, utilized a cane, and did not exhibit wandering behavior. The care plan dated April 2020 identified Resident #1 was at risk for elopement related to one or more attempts to leave the facility at this facility and other facilities, cognitive loss and dementia. Interventions included the use of a Wanderguard secured to the residents left ankle, check the function daily during the night shift, maintain a photo of the resident at the front desk reception area, and divert the resident by giving alternate objects or activities. An Elopement Evaluation dated 6/30/20 identified Resident #1 was able to walk, had a [DIAGNOSES REDACTED]. A physician order [REDACTED]. Review of the Q15 Minute Check (every)Monitoring Roster dated 7/4/20 identified Resident #1's whereabouts were checked every 15 minutes between 8:00 AM and 7:45 PM. Review of the electronic video surveillance of the secure dementia unit located on the second floor of the facility, dated 7/4/20 from 6:00 PM to 9:45 PM identified the following; Between 5:20PM-5:28PM, Resident #1 observed walking up and down the hall with the assist of a cane. At 5:28PM NA#1 observed going into Resident #1's room with a meal tray. At 5:40PM Resident #1 observed walking up the all towards the nurse's station. Between 5:42PM-5:49PM LPN #2 observed taking resident #1 vital signs and administering medications. At 5:51PM, Resident #1 was observed heading back to his/her room. At 5:58PM, Resident #1 walked up the hall towards the nurse's station. At 5:59PM Resident observed walking onto a separate unit momentarily, then turn around and head towards his/her room. No other residents were observed in the area. At 6:03 PM, Resident #1 was seen walking up and down the hall between the nurse's station and his/her room at the end of the hallway, which was adjacent to the fire door, which lead to a stairway At 6:04PM Resident #1 was again observed walking up the hallway and enter onto an alternate unit. No other residents were observed in the area. At 6:05 Resident #1 was observed leaving the alternate unit with LPN #2. At 6:07 PM, LPN #2 was observed gesturing (no audio) to Resident #1, and pointing down towards the resident's room, and Resident #1 walked into his/her room. At 6:08 PM, Resident #1 was observed at the fire door next to his/her room. NA #2 approached the door and Resident #1 went back to his/her room. At 6:09 PM, Resident #1 was observed in front of the fire door. The electronic video monitoring skipped from 6:09PM - 6:12 PM and Resident #1 was no longer viewed on the screen. At 6:13 PM, LPN #1 was observed walking down towards the fire door where the visual at the end was unknown. Resident #1 was not seen on video surveillance after 6:09 PM on 7/4/20. At 6:47 PM, NA#1 was observed going to the entryway of Resident #1's room, then headed back up the hall. At 7:26 PM, LPN #2 was observed going down to Resident #1's room with the medication cart, used the phone in the middle of the hallway, and then walk to the nurse station to use the phone at the front desk. At 7:38 PM, RN #2 is observed entering onto secure dementia unit located on the second floor of the facility but then exits. At 9:39 PM, multiple staff are observed walking in and out of rooms secure dementia unit located on the second floor of the facility. A nursing progress note dated 7/4/20 at 8:49 PM identified Resident #1 was not in his/her room during a room check, the supervisor was made aware and the facility policy for missing person was initiated, including a search of the entire building and premises. Additionally, the resident representative was made aware, and the local police were notified. A Reportable Event Form dated 7/5/20 at 12:46 PM identified Resident #1 had a history of [REDACTED]. On 7/4/20 at 8:00 PM, Resident #1 was last identified to be seen in the facility. All areas were searched, police, physician and family were notified. Resident #1 was found 2.9 miles away in a residential area and returned to the facility by police on 7/4/20 at 11:55 PM. Resident #1 had no injuries noted and the Wanderguard was in place and functioning upon the resident's return. Resident #1 denied pain and a skin assessment was completed upon return. Resident #1 was placed on 1:1 monitoring until a facility investigation was completed. A statement dated 7/5/20 written by LPN #2 identified s/he was the assigned nurse for the 3:00PM-11:00PM shift on 7/4/20. LPN #2 indicated s/he observed Resident #1 talking with other residents on a separate wing of the secured unit and obtained his/her vital signs at 8:00PM. Resident #1 asked how s/he could get back to his/her room and LPN #2 directed Resident #1 down the hall back to his room. LPN #2 indicated when s/he went to administer Resident #1 his medications at 9:00PM, s/he was discovered missing. LPN #2 checked Resident #1's usual spots on the unit and could not locate him/her. Observation on 7/7/20 10:20AM on the third floor identified Resident #1 on 1:1 supervision, on an observational unit located on the third floor, in bed sleeping, with no roommate. Interview with the Administrator on 7/7/20 at 10:50 AM identified she received a call on 7/4/20 at approximately 10:00 PM that Resident #1 was missing, and that staff completed a room/building/ premise search and were driving the streets to search for the missing resident. The Administrator indicated the facility protocol for a missing resident was activated and all parties had been notified. According to the Administrator, LPN #2 administered Resident #1 his/her medications and obtained vital signs at 8:00 PM that night. The assigned nurse's aide, NA #1, indicated she had last seen the resident around dinner time (dinner determined to be at 5:10PM by video surveillance). Resident #1 was found by police at 11:55 PM, fully clothed and brought

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) back to the facility. An assessment was completed and there were no injuries. Resident #1 was placed on 1:1 supervision and on observation for Covid 19 due to unknown exposure during the elopement. The Administrator indicated the facility had surveillance cameras which identified at 6:07PM, Resident #1 was observed walking back and forth from his room to the nurse's station. LPN #1 was seen responding to a door alarm around dinner time at the end of the hallway on the 2nd floor. According to the Administrator, LPN #1 looked down the stairway and didn't see anyone, nor was the resident seen at the door by LPN #1, and she reset the alarm. The facility did not realize Resident #1 was missing until after 9:00 PM. The Administrator indicated the investigation was still in progress and that while Resident #1 had wandering behaviors, he/she had not demonstrated any exit seeking behaviors for a year. An interview with LPN #1 on 7/7/20 at 12:10 PM identified while she was not the assigned nurse for Resident #1, she did observe Resident #1 on secure dementia unit located on the second floor of the facility talking with another resident on the opposite side of the unit sometime before dinner, but did not see Resident #1 any other time. LPN #1 indicated Resident #1's room was at the end of the hallway, next to an alarmed fire door. LPN #1 indicated that the fire door alarm at the end of the hall on secure dementia unit located on the second floor of the facility was sounding sometime around dinner. LPN #1 responded to the sounding alarm by putting a code in the alarm pad next to the door to deactivate the alarm. LPN #1 looked down the stairs at the time the alarm was deactivated and did not see anyone however she did not walk through the area to further investigate. Observation 7/7/20 at 12:30 PM, of the door leading to a stairwell on the second floor where Resident #1 was believed to have exited identified when the alarm was intentionally activated to determine function and response times, once the fire door was deactivated, there was a brief 2 second delay where the door is left unlocked to allow passage. The fire door would also automatically unlock if pushed for 15 seconds. The door exiting to the outside of the building was intentionally alarmed, which sounded at the front entrance, and at the 2nd floor nurse station. While staff from the second floor physically responded to the alarm, staff from the reception area failed to respond to the alarm. An interview on 7/7/20 at 12:30 PM with Receptionist #1 identified that although she heard the alarm to the door exiting the building at the time of activation by surveyor, s/he did not respond as receptionist coverage was being turned over to other staff. Receptionist #1 instead, deactivated the alarm. An interview with the Maintenance Director on 7/7/20 at 12:30PM identified that it is the resposibility of all staff to respond to alarms. A second review of video surveillance dated 7/4/20 between 6:00 and 6:15PM on the secure dementia unit at 6:11 PM, LPN #1 was observed at an alarm panel located at the nurse's station with his/her hand on the panel but undetermined if s/he was activating buttons. A subsequent interview with LPN #1 on 7/7/20 at 1:21 PM identified while s/he was observed at the alarm panel at the nurses station appearing to be pushing buttons on the panel, she did not know how to reset the alarm at the nurse's station alarm panel, did not understand the meaning of the codes, and would not know how to reset any alarm from the nurse's station alarm panel. Video surveillance of the only alternate alarm panel able to be accessed was located at the reception area and was not being accessed by staff at that time. Interview with NA #1 on 7/7/20 at 2:00 PM, and 7/8/20 at 10:15 AM identified she was assigned to Resident #1 during the 3:00 PM - 11:00 PM shift and was responsible for the every 15 minute enhanced supervision monitoring. NA #1 indicated staff must physically verify that a resident is present when placed on every15 minute enhance monitoring. NA #1 indicated Resident #1 was observed periodically in the hallway up until what she believed to be approximately 7:45 PM and based the 15 Minute Check Monitoring Roster dated 7/4/20. NA #1 indicated although she was observed on video surveillance walking to the entryway of Resident #1's room at 6:47 PM, she indicated she was looking for the resident's roommate and did not actually look to see if Resident #1 was in the room. An interview with LPN #2 on 7/7/20 at 3:02 PM identified s/he was the assigned nurse for Resident #1 on 7/4/20 during the 3:00 PM -11:00 PM shift. LPN #2 indicted she obtained vital signs and administered medications at around 5:00 PM to Resident #1(in direct conflict with his/her statement which noted vital signs were obtained at 8:00PM). Video surveillance identified Resident #1's vital signs and medications were obtained between 5:42PM and 5:49PM. LPN #2 believed she had seen Resident #1 at 8:00 PM and redirected the resident back to his/her room for medications. This is in direct conflict with video surveillance that showed Resident #1 being redirected back to his room by LPN #2 between 6:04PM and 6:07PM when LPN #2 was observed gesturing to Resident #1, and pointing down towards the resident's room, LPN #2 indicated s/he did not administer medications to Resident #1 at 8:00 PM and had forgotten to indicate on the MAR indicated [REDACTED]. This is in direct conflict with LPN #2's written statement indicating s/he last saw resident #1 at 8:00PM and later to administer medications at 9:00PM. LPN #2 indicated she was not aware the resident was missing until sometime after 9:00 PM. But in an amended written statement dated 7/7/20 where LPN #2 indicated s/he went to give Resident #1 his medications, that s/he was not in his/her room, so s/he did not administer the medications. Video surveillance noted LPN #2 was observed in front of Resident #1's room with his/her medication cart at 7:26PM. Video surveillance also identified Resident #1 was not observed on any hallway on the unit after 6:09PM. The Administrator directed LPN #2 to amend his/her statement on his/her next scheduled day to the conflict in times of what was previously reported. Attempts to reach LPN #2 for additional information was unsuccessful. Interview with NA #2 on 7/7/20 at 3:21 PM and 5:39 PM identified she was working on secured unit located on the second floor on 7/4/20 during the 3:00 PM - 11:00 PM shift. NA #2 indicated while Resident #1 was not her assigned resident, she responded to a sounding alarm on that unit around dinner time. NA #2 indicated s/he observed Resident #1 standing in front of the fire door at the end of the unit attempting to enter codes into the keypad located adjacent to the fire door. NA #2 indicated she reset the code to deactivate the alarm and while doing so observed Resident #1 enter back into his/her room. NA #2 indicated the alarm activated a second time, and again, s/he observed Resident #1 at the door pushing on the keypad. NA #2 reset the alarm again but did not recall if Resident #1 went back into his/her room a second time. NA #2 indicated she did not report to anyone that Resident #1 was actively displaying exit seeking behaviors, believing resetting the keypad was enough and then left the area. Interview on 7/7/20 at 3:50 PM with Receptionist #2 identified she was assigned to work on 7/4/20 from 3:00 PM - 8:00 PM. Receptionist #2 recalled there was some activity with staff exiting through the right side door (cannot exit through front door in evening hours) and a resident was returning from [MEDICAL TREATMENT]. Receptionist #2 recalled an alarm sounded around or after dinner and that she called the nursing supervisor to reset the alarm. Receptionist #2 indicated she had not received any training on the alarm system and did not know what to do when the alarm sounded so she notified the supervisor. Interview with RN #2 on 7/7/20 at 4:08 PM and 7/9/20 at 10:00AM identified she received a call from the receptionist for a sounding alarm around dinner. RN #2 checked to see the location on the panel located on the second floor. The location indicated the door was open at the loading dock, which would be expected as it was around dinner, and the large doors to the loading dock would be open. After learning what happened, RN #2 thought it was strange in hindsight because the door Resident #1 was believed to have exited through was checked the following day with the Administrator and read DNS stairway door which described the location of the door Resident #1 was believed to have exited through to the outside of the building. RN #2 indicated LPN #2 went to give Resident #1 his/her 9:00 PM medications and discovered the resident was not there. RN #2 indicated she was not notified until 9:30 PM, at which point she activated the policy for a missing resident, and notified the Administrator and DNS. The alarm for the fire door on secured unit on the second floor was also checked and determined to be functioning, noting the fire door would open after being pushed for 15 seconds. RN #2 thought the Resident #1 may have gone down the back stairs and through the exit door at the bottom of the stairwell. Video surveillance dated 7/4/20 identified RN #2 pressing buttons on the alarm panel located at the nurse's station on the second-floor of the secured unit at 6:40 PM. A subsequent interview with the Director of Maintenance on 7/8/20 at 9:30AM identified while each alarm panel identifies the location of the sounding alarm, the alarm will default to the loading dock location once cleared if the door is open, which it often is as it is near the kitchen. Interview with the DNS on 7/9/20 at 9:20 AM identified Resident #1 constantly exhibited exit seeking behaviors. Additionally, the DNS indicated she had no idea the alarmed panel located on the secured unit on the second floor at the nurse's station and reception area could deactivate alarms to the outside of the building. The policy for an Elopement of a Patient dated 5/15/20 notes elopement occurs when a resident leaves the premises without authorization. For any unwitnessed elopement, staff are to search room to room and all areas of the center as well as the outside perimeter and grounds. If the patient is not found, law enforcement, nurse supervisor, Center Executive Director (Administrator) and Center Nurse Executive (DNS) is notified. All staff are to be trained on the center's door security system and required response to the sounding alarm. The policy further directs staff witnessing a confused patient or identified elopement risk patient attempting to leave the center, will intervene as appropriate to redirect the patient to a safe area and prevent elopement. The facility failed to implement adequate supervision for a resident known to wander or exhibit exit seeking behaviors to prevent an elopement, failed to visualize the resident during 15 minute checks and failed to ensure all staff were trained on the door security system including identified location, and required response to alarms.
F 0711 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure the resident's doctor reviews the resident's care, writes, signs and dates**

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	075320	A. BUILDING _____ B. WING _____	07/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST CAMILLUS REHABILITATION & NURSING CENTER	494 ELM ST STAMFORD, CT 06902

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0711 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) **progress notes and orders, at each required visit.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 7 of 7 residents (Resident #1, #2, #3, #4, #5, #6, #7) reviewed for physician services, the facility failed to ensure physician visits were conducted in required time frames according to policy. The findings include: Resident #1 was admitted on [DATE] with [DIAGNOSES REDACTED]. The Admission minimum data set (MDS) assessment dated [DATE] identified Resident #1 was without cognitive impairment and was independent with personal care. The care plan dated 3/5/20 identified Resident #1 was at risk for impaired renal function with interventions that included medications and treatments as ordered and to monitor intake/output and vital signs as ordered. Medical progress notes from both the hard (paper) and electronic clinical record dated 2/11/20 through 7/18/20 did not include a signed progress note signed by a physician. Resident #2 was admitted on [DATE] with [DIAGNOSES REDACTED]. The quarterly MDS assessment dated [DATE] identified Resident #2 was moderately cognitively impaired and independent with personal care. The care plan dated 8/12/20 identified Resident #2 was at risk for cardiovascular symptoms related to hypertensive urgency with interventions that included the administration of medication as ordered and a reassessment of effectiveness. Medical progress notes from both the hard (paper) and electronic clinical record dated 8/5/19 through 7/7/20 did not include a progress note signed by a physician. Resident #3 was admitted on [DATE] with [DIAGNOSES REDACTED]. The significant change MDS assessment dated [DATE] identified Resident #3 was without cognitive impairment and required extensive assist with most ADL skills. The care plan dated 10/15/19 identified Resident #3 was at risk for alteration in discomfort and at risk for complication related to the use of [MEDICAL CONDITION] drugs. Interventions included medicate for signs of discomfort and consider gradual dose reductions in medication as ordered. Medical progress notes from both the hard (paper) and electronic clinical record dated 7/31/19 through 7/23/20 included only one signed physician progress notes [REDACTED].#4 was admitted on [DATE] with [DIAGNOSES REDACTED]. The quarterly MDS assessment dated [DATE] identified Resident #4 was moderately cognitively impaired and required limited assist with personal care. The care plan dated 6/25/20 identified Resident was at risk for hypo/[MEDICAL CONDITION] dur to a [DIAGNOSES REDACTED]. Medical progress notes from both the hard (paper) and electronic clinical record dated 8/6/19 through 7/22/20 did not include a signed physician progress notes [REDACTED]. The quarterly MDS assessment dated [DATE] identified Resident #5 was without cognitive impairment and required extensive assist with personal care. The care plan dated 10/3/19 identified Resident #5 exhibited cardiovascular symptoms or complications related to [MEDICAL CONDITION]. Interventions included the administration of medications as ordered, assess effectiveness and report abnormalities to the physician. Medical progress notes from both the hard (paper) and electronic clinical record dated 9/11/19 through 7/20/20 did not include a signed physician progress notes [REDACTED]. Resident #6 was admitted on [DATE] with [DIAGNOSES REDACTED]. The 5-day MDS assessment dated [DATE] identified Resident #6 was without cognitive impairment and was independent with personal care. The care plan dated 8/20/19 identified Resident #6 was at risk for cardiovascular symptoms or complications related to hypertension and end stage [MEDICAL CONDITION]. Interventions included the administration of medications as ordered, assess for side effects and abnormalities and report to the physician. Medical progress notes from both the hard (paper) and electronic clinical record dated 7/29/19 through 7/20/20 did not include a signed physician progress notes [REDACTED]. The significant change MDS assessment dated [DATE] identified Resident #7 was moderately cognitively impaired and required total assist with personal care. The care plan dated 6/18/19 identified Resident #7 was at risk related to complications related to the use of [MEDICAL CONDITION] drugs. Interventions included to monitor for the continued need of medication related to mood or behavior. Medical progress notes from both the hard (paper) and electronic clinical record dated 9/1/19 through 7/27/20 did not include a signed physician progress notes [REDACTED]. that actual physician visits should occur every 60 days. Physicians are to complete progress notes each time they visit with a resident. An interview on 7/28/20 at 12:41PM with APRN #1 identified s/he worked at the facility Monday -Thursday every week and completed a progress note with every visit. APRN #1 thought that physicians visited residents every 3-6 months. An interview on 7/28/20 at 3:14PM with MD #1 identified s/he had been working remotely due to COVID and having family members affected by COVID. MD #1 identified s/he had not been there often in recent months. MD #1 also indicated the facility APRN's are often onsite and sign progress notes as well. MD #1 added while s/he was not aware of the specific requirements for visitation, s/he would be open to be educated. An interview on 7/29/20 at 10:52AM with the Medical Director identified that when visiting the facility s/he completes a progress note. Many of the notes were in progress meaning started but not yet finished and the Medical Director was planning to complete them going forward. The facility policy for physician visits and review of orders directed that a monthly review of medications is required by the facility physician.
F 0712 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that the resident and his/her doctor meet face-to-face at all required visits.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** F712 Based on review of the clinical record, facility documentation, facility policy, and interviews for 7 of 7 residents (Resident #1, #2, #3, #4, #5, #6, #7) reviewed for physician services, the facility failed to ensure medications and treatments orders included a signature and date. The findings include: Resident #1 was admitted on [DATE] with [DIAGNOSES REDACTED]. The Admission minimum data set (MDS) assessment dated [DATE] identified Resident #1 was without cognitive impairment and was independent with personal care. The care plan dated 3/5/20 identified Resident #1 was at risk for impaired renal function with interventions that included medications and treatments as ordered and monitor intake/output and vital signs as ordered. physician's orders [REDACTED]. The quarterly MDS assessment dated [DATE] identified Resident #2 was moderately cognitively impaired and independent with personal care. The care plan dated 8/12/20 identified Resident #2 was at risk for cardiovascular symptoms related to hypertensive urgency with interventions that included the administration of medication as ordered and a reassessment of effectiveness. physician's orders [REDACTED]. The significant change MDS assessment dated [DATE] identified Resident #3 was without cognitive impairment and required extensive assist with most ADL skills. The care plan dated 10/15/19 identified Resident #3 was at risk for alteration in discomfort and at risk for complication related to the use of [MEDICAL CONDITION] drugs. Interventions included medicate for signs of discomfort and consider gradual dose reductions in medication as ordered. physician's orders [REDACTED]. Resident #4 was admitted on [DATE] with [DIAGNOSES REDACTED]. The quarterly MDS assessment dated [DATE] identified Resident #4 was moderately cognitively impaired and required limited assist with personal care. The care plan dated 6/25/20 identified Resident was at risk for hypo/[MEDICAL CONDITION] dur to a [DIAGNOSES REDACTED]. physician's orders [REDACTED]. The quarterly MDS assessment dated [DATE] identified Resident #5 was without cognitive impairment and required extensive assist with personal care. The care plan dated 10/3/19 identified Resident #5 exhibited cardiovascular symptoms or complications related to [MEDICAL CONDITION]. Interventions included the administration of medications as ordered, assess effectiveness and report abnormalities to the physician. The physician's orders [REDACTED]. The 5-day MDS assessment dated [DATE] identified Resident #6 was without cognitive impairment and was independent with personal care. The care plan dated 8/20/19 identified Resident #6 was at risk for cardiovascular symptoms or complications related to hypertension and end stage [MEDICAL CONDITION]. Interventions included the administration of medications as ordered, assess for side effects and abnormalities and report to the physician. The physician's orders [REDACTED]. The significant change MDS assessment dated [DATE] identified Resident #7 was moderately cognitively impaired and required total assist with personal care. The care plan dated 6/18/19 identified Resident #7 was at risk related to complications related to the use of [MEDICAL CONDITION] drugs. Interventions included to monitor for the continued need of medication related to mood or behavior. The physician's orders [REDACTED]. An interview on 7/28/20 at 11:30AM with the DNS identified medication orders were required to be signed monthly. Either a hard (paper)copy in the chart or electronically. When verification of an electronic signature was requested, the DNS indicated s/he did not know how to determine how to verify an order was electronically signed. The DNS indicated the pharmacy was also contacted for assistance in verifying signed physicians' orders and was informed only controlled substances and intravenous medications required an electronic signature. The DNS indicated there was past noncompliance with this issue but had gotten better until recent months where it was identified as a problem again. The DNS assigned the scheduler to track the orders and remind the physicians to sign the medication orders. An interview on 7/28/20 at 12:41PM with APRN #1 identified while s/he was at the facility Monday -Thursday of every week, she would sign physicians' orders to help the physicians if s/he noticed an order required a signature. However, it was not his /her responsibility to ensure physician's orders [REDACTED].#1 thought that physicians visited residents every 3-6 months and would review medications during the visit. An interview and electronic communication review on 7/28/20 at 1:00PM with

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F 0712 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) Scheduler #1 identified s/he was responsible for tracking the physician orders [REDACTED]. Scheduler #1 indicated emails were sent to the physician's as well as informing them verbally. Any emails with no response were sent again with a copy to the DNS. No email exchanges were saved electronically for review. Scheduler #1indicated it has been a problem that needs to be fixed. An interview on 7/28/20at 3:14PM with MD #1 identified s/he had been working remotely due to COVID and having family members affected by COVID. MD #1 indicated s/he signed orders electronically when made aware but acknowledge he/she had not been there often in recent months. MD #1 added while he was not aware of the specific requirements signing orders, s/he would be open to be educated. An interview on 7/29/20 at 10:52AM with the Medical Director identified that physician orders [REDACTED]. Subsequent to surveyor inquiry Physicians orders dated 7/28/20 were signed for Resident #1- #7. Review of the policy for physician visits directed the attending physician will make required routine visits to the patient every 30, 60 and 90 days after admission and every 60 days thereafter if alternating with an Advanced Practitioner.
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based facility documentation, facility policy, and interviews the facility failed to ensure the nursing staff demonstrated competency in skills and techniques necessary to prevent an elopement. The findings include: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #1 resided on a secure dementia unit located on the second floor of the facility. The quarterly MDS assessment dated [DATE] identified Resident #1 had severely impaired cognition, was independent with supervision for walking, utilized a cane, and did not exhibit wandering behavior. The care plan dated April 2020 identified Resident #1 was at risk for elopement related to one or more attempts to leave the facility at this facility and other facilities, cognitive loss and dementia. Interventions included the use of a Wanderguard secured to the residents left ankle, check the function daily during the night shift, maintain a photo of the resident at the front desk reception area, and divert the resident by giving alternate objects or activities. An Elopement Evaluation dated 6/30/20 identified Resident #1 was able to walk, had a [DIAGNOSES REDACTED]. Review of the Q15 Minute Check (every)Monitoring Roster dated 7/4/20 identified Resident #1's whereabouts were checked every 15 minutes between 8:00 AM and 7:45 PM. Review of the electronic video surveillance of the secure dementia unit located on the second floor of the facility, dated 7/4/20 from 6:00 PM to 9:45 PM identified NA #2 at 6:08PM attempting to exit through a fire door at the end of a unit and next to Resident #1's bedroom. Staff reset the alarm and exited the area without redirecting Resident #1 to a safe area. Resident #1 last seen at 6:12PM attempting to exit through the same fire door. LPN #1 responded to the alarmed door at 6:13PM but did not investigate to ensure a resident had not descended the stairway towards a door leading to the outside of the building. Resident #1 was no longer viewed on video surveillance on any hall on the unit from 6:45PM. At 9:39PM, staff were observed on video surveillance looking in and out of rooms. Subsequent to those events, Resident #1 eloped the premise through the two alarmed doors, and was located by the local police at 11:55 PM, 2.9 miles away and returned to the facility uninjured. An interview with LPN #1 on 7/7/20 at 12:10 PM and on 7/7/20 at 1:21 PM identified she did observe Resident #1 on secure dementia unit located on the second floor and the Resident's room was at the end of the hallway, next to an alarmed fire door. LPN #1 identified the fire door alarm at the end of the hall was sounding sometime around dinner she responded to the sounding alarm by putting a code in the alarm pad next to the door to deactivate the alarm. LPN #1 looked down the stairs at the time the alarm was deactivated and did not see anyone however she did not walk through the area to further investigate. LPN #1 also indicated while s/he was observed at the alarm panel at the nurses station appearing to be pushing buttons on the panel, she did not know how to reset the alarm at the nurse's station alarm panel, did not understand the meaning of the codes, and would not know how to reset any alarm from the nurse's station alarm panel. Observation 7/7/20 at 12:30 PM, of the door leading to a stairwell on the second floor where Resident #1 was believed to have exited identified when the alarm was intentionally activated to determine function and response times, while staff from the second floor physically responded to the alarm, staff from the reception area failed to respond to the alarm. An interview on 7/7/20 at 12:30 PM with Receptionist #1 identified that although s/he heard the alarm to the door exiting the building at the time of activation by surveyor, s/he did not respond as receptionist coverage was being turned over to other staff. Receptionist #1 instead, deactivated the alarm. Interview with NA #1 on 7/7/20 at 2:00 PM, and 7/8/20 at 10:15 AM identified she was assigned to Resident #1 during the 3:00 PM - 11:00 PM shift and was responsible for every 15-minute enhanced supervision monitoring. NA #1 identified the staff must physically verify that a resident is present when placed on every15 minute enhance monitoring. NA #1 identified Resident #1 was observed periodically in the hallway up until what she believed to be approximately 7:45 PM and based the 15 Minute Check Monitoring Roster dated 7/4/20. NA #1 identified that although she was observed on video surveillance walking to the entryway of Resident #1's room at 6:47 PM, she identified she was looking for the resident's roommate and did not actually look to see if Resident #1 was in the room. An interview with LPN #2 on 7/7/20 at 3:02 PM identified s/he was the assigned nurse for Resident #1 on 7/4/20 during the 3:00 PM - 11:00 PM shift. LPN #2 identified s/he was not aware the Resident was missing until sometime after 9:00 PM. But in an amended written statement dated 7/7/20 where LPN #2 indicated s/he went to give Resident #1 his medications, that s/he was not in his/her room, so s/he did not administer the medications. Video surveillance noted LPN #2 was observed in front of Resident #1's room with his/her medication cart at 7:26PM. Video surveillance also identified Resident #1 was not observed on any hallway on the unit after 6:09PM. Attempts to reach LPN #2 for additional information was unsuccessful. Interview with NA #2 on 7/7/20 at 3:21 PM and 5:39 PM identified s/he was working on secured unit located on the second floor on 7/4/20 during the 3:00 PM - 11:00 PM shift. NA #2 indicated s/he responded to a sounding alarm on that unit around dinner time. NA #2 indicated s/he observed Resident #1 standing in front of the fire door at the end of the unit attempting to enter codes into the keypad located adjacent to the fire door. NA #2 indicated she reset the code to deactivate the alarm and while doing so observed Resident #1 enter back into his/her room located next to the fire door. NA #2 indicated the alarm activated a second time, and again, s/he observed Resident #1 at the door pushing on the keypad. NA #2 reset the alarm again but did not recall if Resident #1 went back into his/her room a second time. NA #2 indicated she did not report to anyone that Resident #1 was actively displaying exit seeking behaviors and did not redirect Resident #1 to a safe area when exhibiting exit seeking behaviors believing resetting the keypad was enough and then left the area. Interview on 7/7/20 at 3:50 PM with Receptionist #2 identified she was assigned to work on 7/4/20 from 3:00 PM - 8:00 PM. Receptionist #2 recalled there was some activity with staff exiting through the right side door (cannot exit through front door in evening hours) and a resident was returning from [MEDICAL TREATMENT]. Receptionist #2 recalled an alarm sounded around or after dinner and that she called the nursing supervisor to reset the alarm. Receptionist #2 indicated she had not received any training on the alarm system and did not know what to do when the alarm sounded so she notified the supervisor. Interview with the DNS on 7/9/20 at 9:20 AM identified Resident #1 constantly exhibited exit seeking behaviors. Additionally, the DNS identified she had no idea the alarmed panel located on the secured unit on the second floor at the nurse's station and reception area could deactivate alarms to the outside of the building. The policy for an Elopement of a Patient dated 5/15/20 notes elopement occurs when a resident leaves the premises without authorization. For any unwitnessed elopement, staff are to search room to room and all areas of the center as well as the outside perimeter and grounds. If the patient is not found, law enforcement, nurse supervisor, Center Executive Director (Administrator) and Center Nurse Executive (DNS) is notified. All staff are to be trained on the center's door security system and required response to the sounding alarm. The policy further directs staff witnessing a confused patient or identified elopement risk patient attempting to leave the center, will intervene as appropriate to redirect the patient to a safe area and prevent elopement. The facility failed to ensure the nursing staff demonstrated competency in skills and techniques necessary to prevent an elopement.