STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335640	A. BUILDING _____ B. WING _____	03/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BUFFALO COMMUNITY HEALTHCARE CENTER	1205 DELAWARE AVENUE BUFFALO, NY 14209

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 0624 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Prepare residents for a safe transfer or discharge from the nursing home.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review during an Abbreviated survey (Complaint # NY 948) completed on 3/18/20 the facility did not provide and document sufficient preparation and orientation to residents to a ensure safe and orderly transfer or discharge from the facility for one (Resident #1) of three reviewed for discharge. Specifically, the facility did not actively pursue discharge planning for Resident #1 after their rehabilitation ended and the resident expressed they wanted to leave the facility. The finding is: The policy and procedure titled Discharge Summary and Plan dated 3/2020 documented every resident will be evaluated for his or her discharge needs and will have an individualized post discharge plan. The resident or representative will be involved in the post discharge planning process and informed of the final post discharge plan. Residents will be asked about their interest in returning to the community. If the resident indicates an interest in returning to the community, he or she will be referred to local agencies and support services that can assist in accommodating the residents' post-discharge preferences. The undated Social Worker job description documented the social worker will work with residents in the nursing home by identifying their psychosocial, mental and emotional needs along with providing, developing, and/or aiding in the access of services to meet those needs. Nursing and the Social Worker is responsible for fostering a climate, policies and routines that enabled residents to maximize their individuality, independence and dignity. The climate shall provide residents with the highest practical level of physical, mental and psychosocial well-being and quality of life. Essential functions: develop, maintaining utilizing listing of current community and resources that are useful to residents and their families/ significant others. Understanding the all government requirements for social service documentation. Document progress in meeting the psychosocial needs of residents. Coordinate the resident discharge planning process and make referrals for appropriate home care services prior to the residents return to the community. 1. Resident #1 had [DIAGNOSES REDACTED]. The Minimum Data Set (MDS, a resident assessment tool) dated 12/26/19 documented Resident #1 had moderate cognitive impairments, was understood and understands. Section Q- documented Resident #1 participated in the assessment, the resident's overall goal expectation during the assessment process was left blank. The MDS documented there was an active discharge plan in place to return to the community and that a formal decision had not been determined by the resident or the interdisciplinary team that a community referral contact was not to happen. Review of untitled comprehensive care plan with initiation date of 12/22/2019 revealed there was no discharge care plan developed for Resident #1. Review of the Progress Notes for Social Services from 12/19/19 to 3/15/20 revealed there was one note dated 12/24/19 regarding Resident #1's admission. Review of the IDT (Interdisciplinary Team) Meeting dated 2/19/2020; 2/24/2020; 2/26/2020; 3/3/2020; 3/11/2020 and 3/17/2020 revealed there was no discussion involving discharge planning. Review of a Hospital Discharge Summary dated 12/12/2019 revealed Resident #1 was being discharged to a rehab facility. Review of nursing progress notes revealed the following: - 1/1/20 at 11:12 PM Licensed Piratical Nurse (LPN) #3 documented Resident #1 became increasingly agitated, ranting under his/her breath about finding a way out of this facility and verbalizing to staff that he's/she's going to leave. Walking around with a book bag with close packed inside. Resident refuses to use his/her wheelchair or the walker because the chip on the wheelchair is keeping him/her against their will in the facility. Resident has been wandering through the facility and has planted himself/herself in the main lobby sitting on the couch watching the door. Writer has notified all staff and will continue to monitor Resident #1 for continuing behaviors. - 1/2/2020 at 3:01 PM Registered Nurse (RN) #2 documented Resident #1 went to clinic this AM and refuse to be treated. Resident ran out of the facility with the CNA (certified nursing assistant) chasing behind him/her. Resident #1 using foul language and refusing to follow direction. - 1/2/2020 at 10:24 PM the Director of Nurses (DON) documented they received a call from the Nursing Supervisor. Noting she (Nursing Supervisor) was watching Resident #1 in the lobby. Resident #1 was able push to open the front door with much force. The supervisor went through the door with him/her. She called for the male nurse on the second floor. The male nurse watched the resident. This DON started the paperwork. Nursing supervisor got paperwork ready. Faxed the transfer form to the CPEP (Comprehensive Psychiatric Emergency Program) at the hospital. EMTs (emergency medical technicians) had no problem getting the resident into the ambulance. -1/19/2020 at 11:02 PM LPN #4 documented Resident #1 continued on 15-minute checks. Resident attempting to leave the facility via the front door at approximately 10:00 PM. Resident #1 states he/she does not want to be here. I want out of here. Supervisor notified and spoke with patient at length. Resident #1 agreed to return to floor for the evening and discuss AMA (against medical advice) or discharge in the morning. - 1/20/2020 at 6:49 AM LPN #5 documented Resident #1 riding elevator to first floor half of the shift. Yelling out that they wanted to get out of here and go to their apartment. Resident repeatedly asking where their money was. Resident #1 eventually went to bed approximately 1:30 AM where they remained until approximately 6:45 AM. -2/10/2020 at 10:30 PM Nursing Supervisor (#3) documented Resident #1 was seen in first floor lobby with bag packed stating, I'm going to get out of here now and go handle my busy (sic) and buy me some cigarettes. During the last cigarette break for the day resident was noted to not have any cigarettes and many other residents were reluctant to let him/her borrow one of their cigarettes. To redirect the resident this writer offered some nourishments and to also buy Resident #1 cigarettes of their own. Resident #1 was pleased with the offer and stated that they will go upstairs to their room. -2/19/2020 at 5:12 AM Nursing Supervisor #3 documented they notified by nurse on second floor Resident #1 had packed their bag and was headed to the elevator. Upon arriving to the first-floor lobby Resident #1 was sitting in a chair in close proximity to the front door. The writer asked resident what's troubling them, Resident #1 stated that he/she was ready to get out of this place. He/She had not been giving any money since he's/she's been here, and he/she is ready to go home. Resident #1 was offered a nourishment. Nourishment was accepted followed by Resident #1 being more open to conversation. Resident #1 stated that he/she feels that he/she is trapped in here and the people here took his/her ID. Resident #1 exclaimed that he/she doesn't understand why he/she is still here and why he's/she's been kept here when he/she wants to go home. This writer spent a great deal of time on first floor monitoring resident. -2/21/20 at 11:40 PM the DON documented that he was notified at 09:02 pm that the nursing supervisor at 08:50 pm heard the front door open without the door release lock pushed. The resident got through the front door and the nursing supervisor walked after Resident #1. The resident would not come back. Physical Therapist from the facility got in his vehicle in attempts to assist bringing the resident back to the facility. Police came placed the resident into the police vehicle. Police brought the resident back to the facility. During an interview on 3/16/20 at 3:01 PM the Director of Social Services stated, Resident #1 has attempted a couple of times to elope from the facility. The resident seems to have a plan to get back to his/her previous apartment. He/she was part of an assisted living program and because of his/her TBI ([MEDICAL CONDITION]) he/she may not be able to go back there. The resident has no family or friends. At this time, we do not have a plan for him/her to be discharged . I was trying to get information at one point to get him/her back there. Someone at assisted living program called me a while ago and said he/she would not be able to come back because of his/her TBI and his/her behaviors. I have reached out to program that helps set things up for people who have had TBIs. I did not document anything regarding his/her elopements or discharge plans. I guess I probably should.

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 0624 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) I have a very good report with him/her. There are no discharge plans for him/her. I usually do have a discharge plan for residents so young but right now he/she would need 24-hour supervision and that is why I do not have a discharge plan or care plan for him/her. He/she does not need to be in a nursing home. I just contacted the program that helps TBI patients today. During a telephone interview on 3/16/20 at 5:46 PM the Director of Social Work stated, Just after you left my office earlier, the assisted living called me and said the resident had not lived there for over 5 years. He/she would come and go as you he/she wanted to. Apparently, he/she just left 4-5 years ago and that they have not heard anything about him/her until his accident with his/her TBI. The last 4 years he/she was homeless. They told me that they would definitely take him back, but an application needs to be filled out and sent back and then he/she will be able to go back. They have two different kinds of apartments either were they cook for you or you learn to cook for yourself. The plan was to fill out application and have the Psychiatrist fill out their part of the forms. I did speak to the resident and he/she was agreeable to go back there. During a telephone interview on 3/18/20 at 10:21 AM, the Assistant Program Director for an Assisted Living Program where Resident #1 previously stayed stated Resident #1 had moved out approximately 5 years ago. I was contacted early this week by the Social Worker at the facility where the resident is at, I believe Monday 3/16/20. The Social Worker called regarding possibly discharging him back to the Assisted Living where he/she was previously. I told them that we cannot just bring the resident back here and that a SPOA (Single Point of Access) application would have to be filled out online. This application then goes through the county and they send the information out to the cites best suited for their needs for the housing programs. I do not even know if he/she will be accepted because of his/her TBI. If he/she isn't accepted though, they will make recommendations as to where he/she should go. Prior to Monday 3/16/20, no one from the facility had contacted me regarding the resident coming back here. 415.3(h)(1)(v)
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, interviews and record reviews conducted during an Abbreviated survey (Complaint # NY 948) completed on 3/18/20 the facility did not ensure that each resident receives adequate supervision to prevent accidents for one (Resident #1) of six residents review for accidents. Specifically, the facility did not provide adequate supervision to prevent the resident from eloping from the facility without staff's knowledge. The resident walked out of the facility on 3/14/20 at 10:07 PM through the front lobby door. The resident was not discovered missing until 3/14/20 at 11:05 PM. The finding is: The policy and procedure (P&P) titled Safety and Supervision of Residents dated 3/2020 documented resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. The P&P titled Wandering, Unsafe Resident dated 3/2020 documented the facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement. The staff will identify residents who are at risk for harm because of an unsafe wandering (including elopement). The staff will assess at risk individuals for potentially correctable risk factors related to unsafe wandering. The resident's care plan will indicate the resident is at risk for elopement or other safety issues. Interventions to try to maintain safety, such as a detailed monitoring plan will be included. The P&P titled Elopement Policy dated 4/2018 documented the residents of the facility will be maintained in a safe and secure manner in protected from actual harm while encouraging a restraint free environment. The facility will make every effort to identify the residents who had a potential for elopement. 1. Resident #1 had [DIAGNOSES REDACTED]. The Minimum Data Set (MDS, a resident assessment tool) dated 12/26/19 documented Resident #1 had moderate cognitive impairments, was understood and understands. During an observation at 10:45 AM on 3/16/20 of a video recording of Resident #1 revealed he/she had a jacket with a hood on and was walking up to the front lobby door. Resident #1 played with the wander guard system (security system specifically designed to prevent elopement of residents at risk for elopement) for a few seconds and then pushed the emergency door release bar and opened the door. Resident #1 then exited the front door unaccompied by staff, turned and shut the door behind him/her and left the facility. Time stamp of the video showed this occurred around 10:07 PM. During an observation on 3/16/20 at 11:00 AM the main front door to the facility was an electronically powered sliding glass door. There was a red sign on the door, approximately ten inches long by one inch high, and read, In Emergency Push Open. Next to the sign was a lever, approximately three inches long by one and a half inches high, that read, PUSH. At this time, the Maintenance Director pushed the lever and the door swung open without audible or visual alarm. There was a wander guard sensor and keypad at the main front door. At this time, the Maintenance Director tested the wander guard system using a testing device and a local audible alarm sounded and the door would not slide open with the release button located at the reception desk until the Maintenance Director entered a code into the wander guard keypad. The operation of the push lever was unaffected by the wander guard alarm. During an interview at the time of the observation, the Maintenance Director stated the wander guard feature on the main front door was tested by Maintenance Staff daily and the wander guard audible alarm was local only. There was no alarm when the door is opened with the push lever. The wander guard keypad on this door can only be used to de-activate the wander guard alarm and cannot unlock the door. Review of and Incident/Accident (I/A) Form dated 3/14/2020 documented Resident #1 eloped from the facility at 10:07 PM. Resident #1 was discovered to be missing by staff at 11:05 PM. Resident was noted to be independent with mobility. Resident has made previous attempts to elope. Review of a Narrative Assessment attached to the I/A form completed on 3/15/20 by Registered Nurse (RN) #1, Nursing Supervisor revealed they were alerted at 11:15 PM that Resident #1 was not in their room, the floor was searched, activated code pink and three drivers were dispatched to canvas the area. Three building searches were conducted in succession. Field searches were unsuccessful. This writer drove to Resident #1's last known address and did not find them. At 11:30 PM 911 was activated and officers arrived approximately 11:45 PM and sent out a description of Resident #1 countywide. Resident #1 was discovered via a facility camera review to have left the building at 10:07 PM via the front door by pushing it open and then pushing it closed behind him/her. At 12:00 AM the Administrator and nursing leadership was notified of situation and immediately responded to our location. Both present on site to coordinate search and consult corporate leadership for further advice and consult. Local police informed facility they will watch for him/her on going. Several searches continued by facility staff. Major hospitals and city morgue have been alerted. Review of Resident #1's untitled comprehensive care plan dated 2/22/2020 documented the resident exhibited wandering behavior via wheelchair; was an elopement risk related to self-transfers, refuses to use four wheeled walker/ risk change in environment, cognitive impairment, desire to leave facility unattended, mental illness [MEDICAL CONDITION], and exit seeking. On 2/21/2020 attempted elopement. Interventions/Task included 1:1 (one to one) with residents (post elopement attempt) between the hours of 8:00 PM- 8:00 AM. Hours of 8:00 AM - 8:00 PM every 30- minute checks. Review of Resident #1's Visual/Bedside Kardex Report (guide used by staff to provide care) dated 3/15/2020 documented under safety, 1:1 with residents (post elopement attempt) between the hours of 8:00 PM - 8:00 AM. and hours of 8:00 AM - 8:00 PM every (Q) 30- minute checks. Review of Resident #1's Elopement risk evaluation V2 for Resident #1 dated 2/22/2020 documented a score of 24 and indicated Resident #1 was at high risk for elopement. Review of a one day schedule dated 3/14/2020 evening shift revealed there was no staff member assigned to Resident #1 to complete the 1:1 task. Review of one day schedule dated 3/14/2020 night shift Resident was assigned 1:1 to a staff member (certified nursing assistant #5). Review of an undated Wander Guard List revealed Resident #1 resides on the 2nd floor and has no wander guard and was an elopement risk. Review of an undated High risk for elopement sheet revealed Resident #1 was not on the list. Review of the Order Recap Report dated 3/16/20 revealed a physician's orders [REDACTED]. Review of the Q30- minute checks sheet revealed 30-minute checks were initialed as completed for Resident #1 every half hour on 3/14/20 from 8:00 PM to 10:30 PM. Review of Progress Notes dated 1/1/20 through 2/21/20 revealed the following: -1/1/20 at 11:12 PM Licensed Piratical Nurse (LPN) #3 documented Resident #1 became increasingly agitated, ranting under his/her breath about finding a way out of this facility and verbalizing to staff that he's/she's going to leave. Walking around with a book bag with close packed inside. Resident refuses to use his/her wheelchair or the walker because the chip on the wheelchair is keeping him/her against their will in the facility. Resident has been wandering through the facility and has planted himself/herself in the main lobby sitting on the couch watching the door. Writer has notified all staff and will continue to monitor Resident #1 for continuing behaviors. -1/2/2020 at 3:01 PM Registered Nurse (RN) #2 documented Resident #1 went to clinic this AM and refuse to be treated. Resident ran out of the facility with the CNA (certified

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) nursing assistant) chasing behind him/her. Resident #1 using foul language and refusing to follow direction. -1/2/2020 at 10:24 PM the Director of Nurses (DON) documented they received a call from the Nursing Supervisor. Noting she (Nursing Supervisor) was watching Resident #1 in the lobby. Resident #1 was able push to open the front door with much force. The supervisor went through the door with him/her. She called for the male nurse on the second floor. The male nurse watched the resident. This DON started the paperwork. Nursing supervisor got paperwork ready. Faxed the transfer form to the CPEP (Comprehensive Psychiatric Emergency Program) at the hospital. EMTs (emergency medical technicians) had no problem getting the resident into the ambulance. -1/19/2020 at 11:02 PM LPN #4 documented Resident #1 continued on 15-minute checks. Patient attempting to leave the facility via the front door at approximately 10:00 PM. Resident #1 states he/she does not want to be here. I want out of here. Supervisor notified and spoke with patient at length. Resident #1 agreed to return to floor for the evening and discuss AMA (against medical advice) or discharge in the morning. Following shift nurse aware of 15- minute checks and at risk for elopement. -1/20/2020 at 6:49 AM LPN #5 documented Resident #1 riding elevator to first floor half of the shift. Yelling out that they wanted to get out of here and go to their apartment. Resident repeatedly asking where their money was. Resident #1 eventually went to bed approximately 1:30 AM where they remained until approximately 6:45 AM. -2/10/2020 at 10:30 PM Nursing Supervisor (#3) documented Resident #1 was seen in first floor lobby with bag packed stating, I'm going to get out of here now and go handle my busy (sic) and buy me some cigarettes. During the last cigarette break for the day resident was noted to not have any cigarettes and many other residents were reluctant to let him/her borrow one of their cigarettes. To redirect the resident this writer offered some nourishments and to also buy Resident #1 cigarettes of their own. Resident #1 was pleased with the offer and stated that they will go upstairs to their room. -2/19/2020 at 5:12 AM Nursing Supervisor #3 documented they notified by nurse on second floor Resident #1 had packed their bag and was headed to the elevator. Upon arriving to the first-floor lobby Resident #1 was sitting in a chair in close proximity to the front door. The writer asked resident what's troubling them, Resident #1 stated that he/she was ready to get out of this place. He/She had not been giving any money since he's/she's been here, and he/she is ready to go home. Resident #1 was offered a nourishment. Nourishment was accepted followed by Resident #1 being more open to conversation. Resident #1 stated that he/she feels that he/she is trapped in here and the people here took his/her ID. Resident #1 exclaimed that he/she doesn't understand why he/she is still here and why he's/she's been kept here when he/she wants to go home. This writer spent a great deal of time on first floor monitoring resident. -2/21/20 at 11:40 PM the DON documented that he was notified at 09:02 pm that the nursing supervisor at 08:50 pm heard the front door open without the door release lock pushed. The resident got through the front door and the nursing supervisor walked after Resident #1. The resident would not come back. Physical Therapist from the facility got in his vehicle in attempts to assist bringing the resident back to the facility. Police came placed the resident into the police vehicle. Police brought the resident back to the facility. During an interview on 3/16/20 at 10:30 AM, the Regional Clinical Director stated the main front door to the facility was locked 24 hours per day and to exit through the door, a release button located at the reception desk must be pushed. The reception desk was manned daily from 8:00 AM until 8:00 PM, and after 8:00 PM, the release button was physically locked. The main front door was also equipped with a push lever. On 3/14/20 at 10:05 PM, Resident #1 opened the door using the push lever, exited through the door, then closed the door. This was observed on security camera footage. Resident #1 resided on the Second Floor and must have taken the elevator to the First Floor because the stairway doors are coded and alarmed. The facility's doors and elevators were equipped with a wander guard system, but Resident #1 would not keep the wander guard device on. During an interview on 3/16/20 at 11:55 AM, the Regional Clinical Director stated that Nursing Supervisor RN #1 on 3/14/20 went up to the unit (Second Floor) and reminded the CNAs that someone needed to do 1:1 with Resident #1 at 8:00 PM, but there was no one was specifically assigned. CNA #1 was the residents assigned CNA on that shift but was not necessarily assigned to do 1:1. Sometimes they will have the CNA who has all of their assignment done, do the 1:1. During a telephone interview on 3/16/20 at 1:44 PM CNA #1 stated, Nobody told me I was 1:1 with Resident #1. I was Resident #1's assigned CNA that night but was never told to do the 1:1 at 8:00 PM. I do not know how they determine who is assigned to the 1:1 with Resident #1 on any other night. I am part time and only work one night a week and every other weekend. RN #1 was the supervisor that night and never said at 8:00 PM someone had to be 1:1 with Resident #1. During an interview on 3/16/20 at 2:14 PM CNA #2 stated, I was not aware of anyone being assigned 1:1 with Resident #1. I work 3-11 full time and I do not have Resident #1's room or ever have to take care of Resident #1. The supervisor did not come up to me and say I was 1:1. Most of the times the Supervisor does say who is 1:1. A lot of times people come in specifically to do the 1:1. This resident has attempted many times before to elope. Resident #1 tends to get more antsy when out smoking and doesn't want to come back in. Resident #1 probably will attempt to elope again. Resident #1 really doesn't need to be here; Resident #1 needs to be in a locked unit or needs a lower level of care. During an interview on 3/16/20 at 2:24 PM Resident #1 stated, I left because I wanted to go talk to some people at the place I was found. I just wanted to go talk to them. That is where I stayed until the guy from here picked me up. During an interview on 3/16/20 at 3:01 PM, the Director of Social Services stated Resident #1 has attempted a couple of times to elope from the facility. I did not document anything regarding Resident #1's elopements. I guess I probably should. During an interview on 3/16/20 at 3:30 PM, Licensed Practical Nurse (LPN) #2 stated Resident #1 did not wear a wander guard bracelet and was free to walk around the building, which he/she often did. LPN #1 has heard Resident #1 rant on multiple occasions, mostly about how he/she wanted to be independent. LPN #2 performed 30-minute checks on Resident #1 on 3/14/20 until 8:00 PM, and at 8:00 PM, one-to-one supervision was supposed to begin, but she was not sure who was assigned to perform the one-to-one supervision. Sometimes one-to-one assignments can be pre-arranged by Human Resources or the Scheduler, but in this case, the Supervisor needed to give the one-to-one assignment. On the evening of 3/14/20, she was only required to complete the 30-minute checks until 8:00 PM, but she continued them until her shift ended. She last saw Resident #1 between 10:00 PM and 10:30 PM, and she left the facility for the evening between 10:44 PM and 11:07 PM. Further review of the Q30 minute checks sheet revealed a 30-minute check was completed at 10:30 PM, even though the security camera footage showed Resident #1 left the building at 10:05 PM. LPN #1 stated she accidentally initialed the 10:30 PM box and meant to initial the 9:30 PM box, which appeared blank on the Q30 minute checks sheet. During a telephone interview on 3/16/20 at 5:29 PM CNA #3 stated, I worked till 9:45 PM that night. The resident was not assigned to 1:1 to me that night. No one asked us to be a 1:1 with Resident #1. Resident #1 was not on my assignment. The supervisor did not discuss that Resident #1 needed to be one on one. The supervisor usually assigns the 1:1 or the scheduler will assign them. Resident #1 was in bed when I left. During an interview on 3/16/20 at 6:00 PM, LPN #2 stated it was her initials on Resident #1's electronic medical record relating to the one-to-one supervision of Resident #1 on 3/14/20, and her initials indicate that she was aware of the one-to-one requirement, but not that it was confirmed as completed, because she does not know what happens after her shift ends. LPN #2 further stated if the one-to-one supervision is not already written on the schedule, then the Supervisor assigns it, not herself. The Supervisor needs to confirm that the one-to-one assignment is completed, and this is mainly done when the Supervisor walks the nursing unit floor to observe it. Resident #1's one-to-one supervision was usually pre-arranged by Human Resources or the Scheduler, but on 3/14/20, it was not pre-arranged, so the Supervisor should have assigned it and written it on the assignment sheet at the beginning of the shift, but to her knowledge, the Supervisor did not specifically assign someone to perform Resident #1's one-to-one supervision on 3/14/20. During an interview on 3/17/20 at 9:08 AM the Director of Human Resources/ Staffing stated, I usually try to staff with an extra person on every shift. I try to have 2 extra people on the schedule, but sometimes it does not work with call offs. During the week I designate someone for the 1st and the 2 nd shift because I work from 7:00 AM- 3:00 PM. On the 11:00 PM-7:00 AM shift, I staff enough people for the 1:1 but the supervisor assigns the CNA to the 1:1. Weekends, I staff enough staff for the 1:1 and the supervisor designates that person for 1:1. Some people go with the lesser assignment, meaning the CNA who has the lighter assignment on the unit will do the 1:1. If there is a float scheduled we usually use them for the 1:1. During an interview on 3/17/20 at 9:23 AM RN #1 Supervisor stated, the resident was a 1:1 from 8:00 PM to the morning. The night of the elopement when I came in, I looked at the schedule and they had four CNAs for the evening on the second floor. I did not assign any specific CNA to Resident #1 at that time and I did not write it on anyone's assignment. I was leaving it up to the CNAs as to who was going to do the 1:1. Sometimes staffing will assign it, but the staff will grieve it with the union because of seniority rules. Ninety percent of the time staffing has someone for that assignment, so I do not even think of having to assign someone to 1:1. At the beginning of the shift I will usually get a volunteer for the 1:1 and write on schedule. That night I asked all 4 CNAs for someone to do the 1:1 at 8:00 PM and no one wanted to do it. At that time, I did not assign anyone and was going to go back later to assign someone and I never got back to it. I know it was wrong. During a telephone interview on 3/17/20 at 9:50 AM, LPN #1 stated on 3/14/20 they worked a double shift; 3:00 PM -11:00 PM shift and 11:00 PM -7:00 AM on the 2nd

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335640	A. BUILDING _____ B. WING _____	03/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BUFFALO COMMUNITY HEALTHCARE CENTER	1205 DELAWARE AVENUE BUFFALO, NY 14209

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	(continued... from page 3) floor. Resident #1 was on their assignment during the 3:00 PM to 11:00 PM and did not know what CNA was assigned 1:1 for the 3:00 PM- 11:00 PM shift. Usually an extra CNA was assigned to do the 1:1 or someone volunteers to do the 1:1. During an interview on 3/17/20 at 12:25 PM the DON stated, usually if they know ahead of time that someone is going to be 1:1, staffing will try to accommodate and get an extra CNA and place it on the schedule. But on weekends sometimes you get call-ins and they need to move the schedule around. Staffing would assign a CNA on the 1:1 during the week. On the weekend it would be more difficult for her to do. The Nursing Supervisor should be doing the assigning of the 1:1 on the weekends. Check to see if there was a volunteer first, if no volunteers go to the person with the assignment of resident who is on 1:1. If they say they are not the least senior, the CNA who is least senior would be assigned. The chain of command would be the Nursing supervisor and then the LPN team Leader. If no one was assigned they will call the Nursing Supervisor- it could be the nurse or the CNA themselves. I remember that the supervisor called me to make sure that the 1:1 was still happening around 4:30 PMish just to double check. Bottom line there was not a CNA who was designated and there should have been. The LPN on the floor should be monitoring that as it is on the MAR/ TAR (medical administration record/ treatment administration record). If I was the LPN, I would want to make sure there is a 1:1 before I put my signature on there. I would think LPN #2 should have known that he was 1:1. Also, if the care plans were carefully checked and if the CNA did not see someone, I would expect them to alert either the LPN or Nursing Supervisor. During a telephone interview on 3/17/20 at 12:30 PM, CNA #5 stated either the scheduler will assign the CNA or the RN Supervisor. When the schedule reaches the floor, someone's name is assigned to the 1:1 slot. It is usually not left up to the CNAs to decide who is doing the 1:1. During an interview on 3/17/20 at 2:54 PM, the Regional Clinical Director stated there was not a policy on assigning 1:1. 415.12(h)(2)
F 0908 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Keep all essential equipment working safely.** Based on observation, interview, and record review during an Abbreviated survey (NY 948) completed on 3/18/20, the facility did not maintain all essential mechanical, electrical and patient care equipment in safe operating condition. Issues included horizontal doors at the front entry were not designed to restrict egress to residents at risk of elopement, doors equipped with Wander Guard (device to detect wandering) mechanisms were not tested daily per facility testing policy, and Wander Guard mechanisms were set to night mode rendering local alarms silenced. This affected three (First, Second, and Third Floors) of three resident use floors. The findings are: Review of a policy and procedure titled Wanderguard System, effective 10/97 and revised 3/20, revealed the facility will provide and maintain a secure environment to prevent negative outcomes for residents who exhibit unsafe wandering and/or elopement behavior. The policy and procedure also stated the 'No Wander Alert System' alarms when a wanderer or potential eloper attempts to leave the facility unaccompanied. It further stated maintenance or designee must check at least daily that all points of the wanderguard alarm systems are functioning properly. 1) Review of the facility's door check log titled, Wander-Guard Daily Check Sheet revealed when the Wander Guard alarm is activated at the sliding lobby door, the door should be locked and should not be able to swing open with the emergency door handle. During an interview on 3/16/20 at 10:30 AM, the Regional Clinical Director stated the main front door to the facility is locked 24 hours per day and to exit through the door, a release button located at the Reception Desk must be pushed. She further stated the Reception Desk is manned daily from 8:00 AM until 8:00 PM, and after 8:00 PM, the release button is physically locked. The Regional Clinical Director also stated the main front door is also equipped with a push lever. She further explained that the facility's doors and elevators are equipped with a Wander Guard system. Observation on 3/16/20 at 11:00 AM revealed the main front door to the facility was an electronically powered sliding glass door. A red sign attached to the door, approximately ten inches long by one inch high, read, In Emergency Push Open. Next to the sign, was a lever, approximately three inches long by one and a half inches high, that read, PUSH. At this time, the Maintenance Director pushed the lever and the door swung open without activating audible or visual alarms. Further observation revealed there was a Wander Guard sensor and keypad at the main front door. At this time, the Maintenance Director tested the Wander Guard system using a testing device. A local audible alarm sounded, and the door did not slide open horizontally with the release button located at the Reception Desk, until the Maintenance Director entered a code into the Wander Guard keypad. The operation of the push lever on the door was unaffected by the activation of the Wander Guard alarm, and the door did swing open when the lever was pushed. During an interview at the time of the observation, the Maintenance Director stated the Wander Guard feature on the main front door is tested by Maintenance Staff daily and the Wander Guard audible alarm is local only. He further stated there was no alarm when the door is opened with the push lever, and he has worked at this facility for seven months, and during that time, there has never been such an alarm. The Maintenance Director also stated the Wander Guard keypad on this door can only be used to de-activate the Wander Guard alarm and cannot unlock the door. During an interview on 3/16/20 at 11:55 AM, the Maintenance Director stated there is no audible alarm on the main front door's push lever, and in his opinion, there should be one because there is no way to know if the lever has been used to open the door. 2. Record review of the facility's door check log titled, Wander-Guard Daily Check Sheet revealed it stated, Check all Wander Guard devices daily. Further review of the Wander-Guard Daily Check Sheet revealed it listed Wander Guard devices on five doors (four on the First Floor and one on the Second Floor) and two elevators, and each daily log indicated these five devices were checked daily by Maintenance Staff. Observations made with the Maintenance Director throughout the facility on 3/16/20 from 5:15 PM until 5:45 PM revealed the facility had eleven doors (five doors on the First Floor, four doors on the Second Floor, and two doors on the Third Floor) that were equipped with Wander Guard devices. Continued observation revealed the doors that were not represented on the Wander-Guard Daily Check Sheet were: First Floor Center Stairway, Second Floor East Stairway, Second Floor West Stairway, Second Floor West Patio, Third Floor East Stairway, and Third Floor West Stairway. During an interview on 3/16/20 at 5:30 PM, the Maintenance Director stated he was not aware that all doors protected with Wander Guard in the facility were not on the Wander-Guard Daily Check Sheet, and Maintenance Staff should have been testing all Wander Guard doors daily, including the doors that were not on the list. 3. Observation on 3/16/20 from 5:15 PM until 5:45 PM revealed when the Maintenance Director tested eleven Wander Guard devices with the testing device, the Wander Guard keypad display on ten of eleven door devices displayed Night Mode, and no audible alarm sounded. During an interview on 3/16/20 at 5:40 PM, the Maintenance Director stated, Night Mode means the Wander Guard device picked up the signal from the testing device but did not sound the audible alarm. He was not sure why all, but one Wander Guard alarms were in Night Mode. Additionally, on 3/16/20 at 6:00 PM, the Maintenance Director stated he was just advised that the Night Mode is scheduled to automatically start daily at 3:00 PM and continue through 7:00 AM. Review of the facility's door check log titled, Wander-Guard Daily Check Sheet revealed it provided testing instructions and said, Night mode is 1,3,4,2 and should not be used at any time, if any unit is not functioning properly the Director of Nursing, RCC of the floor, Administrator and the Director of Environmental Services needs to be contacted immediately for residents' special lobby door mag-lock testing procedure. During an interview on 3/17/19 at approximately 10:30 AM, the Maintenance Director clarified the wording of the Wander-Guard Daily Check Sheet and stated if the Wander Guard keypads were not functioning properly, then the night mode should not have been used. He further stated the Wander-Guard Daily Check Sheet did not mean that night mode should not be used at any time. 415.29(b)