STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225218	A. BUILDING _____ B. WING _____	09/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OXFORD REHABILITATION & HEALTH CARE CENTER, THE	689 MAIN STREET HAVERHILL, MA 01830

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 -** 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 records reviewed and interviews, for one of three sampled residents (Resident #), a severely cognitively impaired resident, assessed as being at risk for elopement and who unsafe to leave the Facility unattended, the Facility failed to provide adequate supervision to Resident #1, when on [DATE], Resident #1, eloped from his/her locked unit, and was found on the ground outside of the Facility by a community member. Resident #1 was transferred to the hospital where he/she was diagnosed with [REDACTED]. Findings include: Resident #1's was admitted to the Facility in [DATE], with [DIAGNOSES REDACTED]. Review of Resident #1's medical record indicated his/her Health Care Proxy was invoked in [DATE], due to dementia and his/her inability to make or communicate his/her own health care decisions. The Elopement and Wandering Assessment, dated [DATE], indicated Resident #1 was at risk of an elopement as he/she expressed the desire to leave the Facility and exhibited exit seeking behaviors, such as trying the doors and packing his/her belongings. The Psychiatric Nurse Practitioner Note, dated [DATE], indicated Resident #1's exit seeking behaviors continued to persist. Resident #1's Quarterly Minimum Data Set, dated dated [DATE], indicated that he/she had severe cognitive impairments and he/she used a wander guard bracelet due to his/her wandering behaviors. Resident #1's Plan of Care, dated [DATE], indicated that Resident #1 required staff redirection when he/she attempted to go down the stairs and/or the elevator in attempts to go to his/her daughters across the street. Resident #1's Plan of Care, dated [DATE], indicated Resident #1 was at risk for falls and required a walker to assist him/her with safe ambulation. The Interdisciplinary Team Meeting Note, dated [DATE], indicated Resident #1 had a wander guard bracelet in place. The Facility's Investigation, dated [DATE], indicated that at 10:15 P.M. Resident #1 was seen on the security camera using the alarm system number pad to successfully enter the alarm code to unlock, then open the door and exit the care unit. The Investigation indicated Resident #1 went down the stairs and he/she exited through an emergency fire exit, which was an alarmed door. The Investigation indicated that at approximately 10:30 P.M., the Security Guard was completing security rounds and when he opened the door to one of the stairways, he heard the emergency exit door's alarm sounding. The Investigation indicated a Dr.(NAME)(missing resident) page was initiated. The Investigation indicated Nurse #2 identified Resident #1 as the missing resident; and she went outside to search for Resident #1. The Investigation indicated that when Nurse #2 found Resident #1, he/she was already being attended to by the local Fire Department and Emergency Medical Technicians (EMT) and he/she was transferred to the hospital. Review of the report submitted to the Department of Public Health via the Health Care Facility Reporting System (HCFRS), dated, [DATE], indicated the local Fire Department found Resident #1 on the ground, approximately 200 feet from the Facility and he/she was transported to the Hospital Emergency Department for evaluation. The Hospital Record, dated [DATE], indicated Resident #1 presented to the hospital after a bystander found him/her in the community and that the Hospital notified the Facility that he/she was in the Emergency Department being evaluated. The Record indicated Resident #1 had a bruise on his/her hip. Resident #1's Nurse Progress Note, dated [DATE], indicated that the Security Guard went to Resident #1's care unit and said that an emergency exit door's alarm was sounding. The Note indicated staff completed a head count and Resident #1 was not in his/her bed. The Note indicated that Nurse #2 went to check outside of the building for Resident #1 and saw Resident #1 being attended to by Emergency Medical Technicians. During an interview on [DATE] at 11:00 A.M., Nurse #2 said Resident #1 frequently wanders and asked to leave the Facility to go see his/her family. Nurse #2 said that as soon as the Security Guard said a resident may be missing, she went right to Resident #1's room to check if he/she was still lying in bed. Nurse #2 said she left the Facility to go look for Resident #1 which is when she found him/her being attended to by emergency personnel down the road. Nurse #2 said she was unsure how Resident #1 eloped from the Facility. The physician progress notes [REDACTED].#1 had increased exit seeking behaviors and managed to leave the Facility on [DATE], had returned to the Facility, and that Resident #1 was not safe to leave the Facility by him/herself. The Facility's Policy, titled Elopement, dated July, 2015, indicated elopement is defined as the ability of a resident who was not capable of protecting him/herself from harm to successfully leave the Facility unsupervised and unnoticed and who may enter into harm's way. The Facility's Policy, titled Wander Management System, dated [DATE], indicated the Policy was used for residents at risk for elopement as assessed and determined by the interdisciplinary team. During an interview on [DATE] at 5:00 P.M., the Security Guard said he completed rounds at approximately 10:00 P.M. and he saw an emergency exit door open and the alarm was sounding. The Security Guard said he did not hear the alarm sounding while he was in the lobby because the door into the staircase was shut and the alarm was not loud enough to be heard. The Security Guard said he saw ambulance lights outside through the open door so he went to the three different floors/units and asked the staff to complete a head count due to concerns of a potentially missing resident. The Security Guard said that approximately ,[DATE] minutes had passed from when he saw the opened emergency exit door until a nurse (later identified as Nurse #2) identified Resident #1 as missing. The Security Guard they found Resident #1 down the street being attended to by EMT's. During an interview on [DATE] at 9:30 A.M., the Administrator said he reviewed the security camera footage as part of the Facility's investigation and he saw Resident #1 use the numbered key pad to successfully unlock the door after two or three attempts. The Administrator said Resident #1 exited the unit door and walked from the third floor to the ground floor, where he/she exited the emergency exit door egress and set off the alarm. On [DATE], the Facility was found to be in Past Non-Compliance and presented the Surveyor with a plan of correction which addressed the area(s) of concern as evidenced by: A. Resident #1 returned to the Facility and his/her safety has been maintained since the elopement on [DATE]. B. All residents were re-assessed by the Assistant Director of Nurses (ADON) on [DATE], for the potential to by adversely affected by concern area, elopement from the Facility. C. On [DATE], the ADON completed Care Plan Audits for all residents in the Facility. D. All staff members were in-serviced by the ADON (from [DATE] to [DATE]) on the Facility's Elopement/Wandering Policy. E. Staff will continue to complete wander guard checks to ensure bracelets are not expired and working appropriately. F. The Facility changed the code to the alarm, and if a resident pushes on Unit Emergency Exit Door in an attempt to leave unit, an alarm will sound. G. The Facility added an additional alarm sensor on the Unit Emergency Exit door, that sounds when door is opened, even with code, and staff were in-serviced on addition of second alarm. H. The Facility had the volume of the Emergency Exit Door (egress door at bottom of stairs) increased so it can be heard by staff on Units, if activated. I. Concern area (elopement) addressed at QAPI and will continue to be discussed with the committee as needed for compliance and safety. J. The Director of Nurses/ADON is responsible for overall compliance.

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