

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075192	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/04/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Meriden		STREET ADDRESS, CITY, STATE, ZIP CODE 845 Paddock Ave Meriden, CT 06450	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32738</p> <p>Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #1) reviewed for elopement, the facility failed to ensure the resident who was a known to wander, had physician's orders and a care plan in place for a wanderguard in accordance with facility policy. The findings include:</p> <p>Resident #1 was admitted to the facility with diagnoses that included metabolic encephalopathy, alcohol induced dementia and anxiety.</p> <p>The nursing admission assessment dated [DATE] identified Resident #1 was not able to ambulate, or self propel a wheelchair independently, therefore Resident #1 was not at risk for an elopement.</p> <p>The admission MDS dated [DATE] identified Resident #1 had moderately impaired cognition and requires assistance with ADLs.</p> <p>A nurses note dated 8/12/24 at 5:18 AM written by LPN #2 identified Resident #1 slept partially that shift and a wanderguard was in place.</p> <p>Psychiatric notes dated 8/15/24 , 8/25, 8/28, 9/5/24 and 9/9/24 identified per staff report Resident #1 wandered and went into other resident's rooms. Resident #1 was forgetful with chronic confusion however re-directable.</p> <p>.</p> <p>A SW note dated 8/15/24 identified a family meeting was held due to Resident #1 walking all over the building and going into other resident's belongings and rooms. The team and family agreed that the resident needed to be placed in a locked dementia unit for his/her safety due to dementia. On 8/16/24 a referral was made to another nursing facility.</p> <p>The care plan dated 8/25/24 identified Resident #1 was at risk for decreased ability to perform ADL's. Interventions included assist of one staff for transfers and ambulation with rolling walker as tolerated. The care plan further identified Resident #1 had the potential for impaired cognitive function related to metabolic encephalopathy. Interventions included to cue, reorient and supervise as needed.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A nursing note dated 8/27/24 at 6:13 AM identified Resident #1's wandering occurred daily or almost daily and posed a significant risk and/or is intruding on others.</p> <p>A nursing note dated 8/31/24 at 2:16 PM identified Resident #1 was wandering at times and a wanderguard was in place and functioning.</p> <p>Review of Resident #1's medical record failed to identify an elopement assessment, progress note and care plan was in place for Resident #1's wanderguard.</p> <p>RN #1 nursing note dated 9/9/24 at 12:03 PM identified an elopement risk assessment was completed. It identified Resident #1 had short and long term memory loss, was disorientated, had impaired decision making ability and delusions and hallucinations which could contribute to an elopement risk. Resident #1 was wandering and restless.</p> <p>The elopement risk assessment dated [DATE] identified Resident #1 scored a nine (9) which identified he/she was a moderate risk for elopement.</p> <p>The care plan dated 9/9/25 identified Resident #1 was at risk for an elopement related to cognitive loss/dementia/wandering behavior and a wanderguard was in place. Interventions included to monitor the resident's location with visual checks at least every 1-2 hours as needed.</p> <p>The accident and incident form dated 9/10/24 identified around 4:30 PM Resident #1 was observed sitting in the hallway of the 300 unit. Around 4:45 PM, Resident #1 was identified not in his/her room and the charge nurse began to search for him/her. The charge nurse alerted the supervisor who instructed all staff to begin searching for the resident. The supervisor notified the DNS, Administrator, Resident #1's family and the police. A few hours later, the facility received notice that Resident #1 was found wandering near a nearby facility (0.3 miles away) and an ambulance was dispatched. Around 9:00 PM the hospital called to report Resident #1 would return to the facility.</p> <p>Review of the physician's orders failed to identify wanderguard orders were in place prior to Resident #1's elopement on 9/10/24.</p> <p>A physician's order dated 9/10/24 directed wanderguard elopement device to right ankle due to poor safety awareness, expiration date of 10/2027 and check the function every night shift.</p> <p>Interview with LPN #2 on 10/1/24 at 11:30 AM identified Resident #1 had a wanderguard on his/her left ankle. She identified she did not place the wanderguard on Resident #1 but identified he/she already had it on. She identified she would not test the wanderguard for function but the 11:00 PM - 7:00 AM shift would check for functioning.</p> <p>Interview with RN #3 (11:00 PM - 7:00 AM supervisor) on 10/1/24 at 11:55 AM identified Resident #1 had a history of wandering into other resident's rooms. She identified she could not remember if Resident #1 had a wanderguard on previous to 9/10/24. She identified she did not place a wanderguard on Resident #1 prior to 9/10/24. She further identified for resident's with a wanderguard, the placement and function checks should be put in as a physician's order.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with RN #1 (3:00 PM - 11:00 PM supervisor) on 10/1/24 at 12:43 PM identified Resident #1 would wander aimlessly. She did not know when Resident #1's wanderguard was placed. She identified any nurse can put a wanderguard on a resident but needs to complete an elopement assessment, get a physician's order, write a progress note, update the care plan and .</p> <p>Interview with the DNS on 10/1/24 at 1:00 PM identified she did not know who put on Resident #1's initial wanderguard. She identified any nurse can put a wanderguard on a resident if the elopement assessment deemed them at risk for if a resident was attempting to leave. She identified the following should occur; an elopement assessment, physician orders received, tell the family/appointed person, put in orders for the wanderguard including expiration date, nursing note as to why the wanderguard was placed and update the care plan, however none was evident prior to 9/10/24.</p> <p>Review of the wandering policy directed 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.</p> <p>Review of the elopements and wandering residents policy identified the facility ensures residents who exhibit wandering behavior and/or are at risk for elopement received adequate supervision to prevent accidents and receive care in accordance with their person centered plan of care addressing the unique factors contributing to wandering or elopement risk.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32738</p> <p>Based on a review of clinical records, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #1) reviewed for elopement, the facility failed to provide the necessary supervision to prevent elopement. As a result, Resident #1 who had cognitive impairment and was at risk for elopement was able to exit the building unsupervised, resulting in a finding of Immediate Jeopardy, past non-compliance. The finding includes:</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy, alcohol induced dementia and anxiety.</p> <p>The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) of seven (7) indicative of moderate cognitive impairment and required supervision with Activities of Daily Living (ADLs) including ambulation.</p> <p>A Social Work (SW) note dated 8/15/24 identified a family meeting was held due to Resident #1 walking all over the building and going into other resident's rooms. The interdisciplinary team and family agreed that the resident would need to be transferred to a facility with a secured dementia unit for his/her safety. The referral process was started on 8/16/24.</p> <p>The care plan dated 8/25/24 identified Resident #1 had the potential for impaired cognitive function related to metabolic encephalopathy with interventions that included to cue, reorient and supervise as needed.</p> <p>Psychiatric notes dated 8/15, 8/28, 9/5 and 9/9/24 identified Resident #1 was seen due to concerns of wandering behaviors. Resident #1 presented with significant cognitive impairment, almost manic-like, confused, poor executive functioning, very poor impulse control with cognitive deficits quite evident, the resident would benefit from a secured dementia unit. Medication adjustments were made to prevent psychiatric hospitalization .</p> <p>A nurse's note dated 9/9/24 at 12:03 PM written by Registered Nurse (RN) #1 identified that Resident #1 was wandering and restless. An elopement risk assessment was completed. The assessment identified Resident #1 had short- and long-term memory loss, was confused, had impaired decision-making ability and delusions and hallucinations which could contribute to an elopement risk.</p> <p>The elopement risk assessment dated [DATE] identified Resident #1 scored a nine (9) which identified a moderate risk for elopement.</p> <p>An interim care plan dated 9/9/25 identified Resident #1 was at risk for an elopement related to cognitive loss/dementia/wandering behavior and a wander guard (a bracelet placed on a resident to alert staff when a resident approaches an exit door) was in place with interventions that directed to monitor the resident's location with visual checks at least every 1-2 hours as needed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A reportable event form dated 9/10/24 identified at approximately 4:30 PM Resident #1 was observed sitting in the hallway of the 300 unit. Around 4:45 PM, Resident #1 could not be located, and the charge nurse (LPN#1) began to search for the resident. The charge nurse alerted the nursing supervisor who instructed all staff to begin searching for the resident. The supervisor notified the Director of Nursing Services, Administrator, Resident #1's family and the police department. The reportable event summary identified that #1 was found wandering next to a nearby facility (0.3 miles away), had complaints of chest pain and was sent to the emergency department where police later located Resident #1 around 6:45 PM. Around 9:00 PM the hospital called to report Resident #1 would return to the facility.</p> <p>Observation and interview with the Director of Maintenance on of the 300-unit emergency exit door on 10/1/24 at 10:00 AM identified that the emergency door was not equipped with a wander guard alert system. When the door is opened, an alarm will immediately sound to alert the staff the door has been opened, a numeric code must be placed into the keypad by staff to silence and reset the alarm.</p> <p>Interview with Nurse Aide (NA) #1 on 10/1/24 at 12:52 PM identified on 9/10/24 she last saw Resident #1 sitting in the hallway around 3:30 PM. NA #1 identified sometime prior to dinner being served (4:30 PM), the emergency door in unit 300 alarmed, she responded, the door was closed, so she entered the numeric code to reset and silence the alarm and continued providing care to her assigned residents. NA #1 identified she became aware that Resident #1 was missing, although could not state the time or how she became aware the resident was missing. NA #1 then informed the nursing supervisor, RN #1, that she could not find Resident #1. NA #1 identified that she was unaware that when the door alarm sounded, she needed to investigate why the alarm sounded which included looking outside to see if a resident exited.</p> <p>Facility documentation identified that NA #1 was educated in 2023 on the elopement and door alarm policy.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 10/1/24 at 11:22 AM identified on 9/10/24 around 4:20 PM, NA #1 informed her that Resident #1 was missing. At 4:30 PM LPN #1 informed Registered Nurse (RN) #2 that she could not locate Resident #1, they both began to search the facility. LPN #1 identified she did not page for a Dr. Hunt when the resident could not be located and was not aware that a Dr. Hunt needed to be called because she was not given education on the elopement policy.</p> <p>Facility documentation identified that LPN#1 was educated on the elopement policy in 2023.</p> <p>Interview with RN #2 on 10/2/24 at 10:15 AM identified on 9/10/24 at 4:30 PM LPN #1 informed him she could not locate Resident #1. RN #2 identified he stopped his medication pass and started looking for Resident #1 and did not tell the supervisor that Resident #1 was missing or page Dr. Hunt because he was busy trying to locate Resident #1.</p> <p>Interview with RN #1 on 10/2/24 at 2:22 PM identified on 9/10/24 she was working the floor in the 400 unit and supervising the building. RN #1 identified around 5:00 PM, NA #1 called her from the 300 unit and asked if she had seen Resident #1. RN #1 stated she paged Dr. Hunt overhead, but the page was unclear, so she went to each department and unit to tell them Resident #1 was missing. A search of the facility and facility grounds was conducted, and Resident #1 could not be located, and the police were notified.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview with the DNS on 10/1/24 at 1:48 PM identified when a door alarm goes off, all staff are to investigate why the door is alarming, and step outside to ensure a resident has not exited. The DNS identified NA #1 should have looked outside when the emergency door alarmed, and LPN #1 and RN #2 should have called a Dr. Hunt and notified the nursing supervisor when the resident was first identified as missing. The DNS identified that Dr. Hunt was paged around 5:00 PM by RN #1 (approximately 40 minutes after Resident #1 was first identified as missing).</p> <p>Review of the elopement prevention and management policy identified the facility ensures residents who exhibit wandering behavior and/or are at risk for elopement received adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. It further identified an elopement as defined by when a resident leaves the physical structure of the facility unattended and without staff knowledge.</p> <p>Review of the elopements and wandering resident's policy directed alarms are not a replacement for necessary supervision and staff are to be vigilant in responding to alarms in a timely manner. It further directed the procedure for locating a missing resident is as follows: any staff member becoming aware of a missing resident will alert personnel using facility approved protocol (e.g. internal alert code), the designated facility staff will look for the resident, if the resident is not located in the building or on the grounds, the Administrator or designee will notify the police department, DNS or designee shall notify the physician and family member or legal representative.</p>