

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/13/2026
NAME OF PROVIDER OR SUPPLIER River Glen Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 162 South Britain Rd Southbury, CT 06488	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observation, review of the clinical record, facility documentation and facility policy, and interviews for one resident (Resident #1) reviewed for accidents, the facility failed to ensure adequate supervision to prevent a resident from leaving the facility without staff knowledge after they were notified the resident was planning to leave the facility, and failed to ensure a complete investigation was completed after a resident left the facility without staff knowledge. The facility failed to implement appropriate interventions after they became aware of the resident's intent to leave the facility, resulting in the resident exiting the building unescorted and without staff knowledge. The findings include: Resident #1's diagnoses included cerebral infarction, atrial fibrillation, chronic kidney disease, dysphagia, and aphasia. The Resident Care Plan dated 5/19/26 identified Resident #1 is at risk for difficulty understanding/communicating related to expressive/receptive aphasia. Interventions include minimizing excess noise. Using yes/no questions and responses when able. Gaining the resident's attention before initiating conversation. Mirroring the resident's facial expressions and body language to demonstrate understanding. Providing reassurance and patience with repetition of information as needed. Obtaining Speech-Language Pathology evaluation and treatment as ordered. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of three out of fifteen (3/15), indicating of being severely cognitively impaired. Resident #1 had no wandering behaviors and ambulated independently. Review of the State of Connecticut Probate Court documentation dated 5/26/26 revealed Resident #1 was under a court-appointed conservatorship, with Person #1 being appointed for both the person and estate. A social services progress note dated 6/19/26 at 3:55 PM by SW #1 identified SW #1 received a call from Person #1. He/she stated that Resident #1 had called Person #1 to let him/her know that Resident #1 is calling an uber and he/she is heading home. Person #1 had sent Person #1 a picture of him/her packing his/her belongings. Person #1 added that Resident #1 does not understand that he/she needs to wait for staff through the state program. SW #1 alerted RN #1 and receptionist. A nursing progress note dated 6/20/26 at 12:13 AM by RN #2 identified at beginning of evening shift, DON (Director of Nursing) reported to RN #2 that Resident #1 had left building via uber earlier today. RN #2 called APRN #1 regarding the above and Social Services updated as well. DON updated RN #2 that Person #1 would be coming this evening at 7:00 PM to sign discharge paperwork. At 9:00 PM, Person #1 had not arrived to SNF (skilled nursing facility) to sign paperwork, RN #2 called Person #1, and indicated he/she will not be coming to sign paperwork, wants paperwork emailed to him/her, RN #2 updated DNS. Interview with the DON, Social Worker (SW) #1, and the Administrator on 7/13/26 at 10:40 AM identified Resident #1 was alert and oriented to place and family and had aphasia, which limited his/her ability to communicate effectively. The team stated (continued on next page)		

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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 had no prior history of elopement behaviors while residing at the facility. The DON, SW #1, and Administrator initially stated Person #1 had not notified them of Resident #1's intention to leave the facility. However, SW #1 clarified that on 6/19/26, at approximately 1:00 PM, Person #1 contacted her and reported Resident #1 had sent photographs showing he/she was packing his/her belongings and intended to leave the facility. SW #1 immediately notified RN #1 and confirmed Resident #1 remained in his/her room. SW #1 then left the area while RN #1 continued to assess the situation and attempted to apply a wander guard; however, Resident #1 refused the device. SW #1 further stated Person #1 contacted the facility again between approximately 2:30 PM and 3:00 PM and reported Resident #1 had arrived home. The DON acknowledged that, despite Resident #1 refusing the wander guard, additional interventions should have been implemented to ensure the resident's safety, including increased monitoring, frequent safety checks, or one-to-one supervision. The DON confirmed no additional supervision, or monitoring interventions were initiated after the facility became aware of Resident #1's intent to leave. The DON and Administrator stated the interdisciplinary team considered the incident an against medical advice (AMA) departure rather than an elopement because Resident #1 chose to leave before discharge services could be arranged. Interview with RN #1 on 7/13/26 at 11:45 AM identified she received a call from the receptionist reporting that Person #1 had contacted the facility and stated Resident #1 intended to leave the facility. RN #1 immediately went to Resident #1's room, confirmed the resident was present, and asked if he/she planned to leave. Resident #1 denied any intention to leave, and RN #1 stated she did not observe any indications the resident was preparing to leave, such as packed belongings. Due to the concern reported by Person #1, RN #1 attempted to apply a Wander guard device; however, Resident #1 refused. RN #1 stated she did not implement any additional interventions because Resident #1 denied planning to leave. RN #1 notified the DON and first-floor nursing staff of the reported concern but confirmed no increased supervision, frequent monitoring, or other safety interventions were initiated. RN #1 stated she updated the DON regarding the situation during a facility team meeting at approximately 2:30 PM and recalled the last time she observed Resident #1 was between approximately 2:00 PM and 2:30 PM. At approximately 3:30 PM, while with the DON, a staff member informed them that Person #1 had contacted the facility and reported Resident #1 had arrived home. Interview with the DON on 7/13/26 at 1:30 PM identified the facility did not report Resident #1's 6/19/26 unescorted departure to the State agency and did not conduct an investigation into the incident because the facility determined Resident #1's departure was an against medical advice (AMA) discharge rather than a reportable unescorted departure/elopement event. Review of facility documentation and staff interviews identified the facility did not conduct an investigation into the circumstances surrounding Resident #1's unescorted exit from the building. Despite the resident leaving the facility without staff knowledge and later being confirmed at home by Person #1, the facility was unable to provide documentation of an investigation to determine how the resident exited the building, identify contributing factors, or implement corrective actions to prevent a recurrence. Review of the Wandering and Elopements Policy dated 03/2019 identified the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.		