STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075252	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westside Care Center	349 Bidwell Street Manchester, CT 06040

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 clinical record review, facility documentation review, facility policy review, and interviews for one of two residents (Resident #1), reviewed for accidents, the facility failed to ensure adequate supervision for a resident while at an outpatient dental appointment. The findings include: Resident #1 was admitted to the facility with diagnoses that included dementia, diabetes mellitus and stroke. The Resident Care Plan (RCP) dated 3/26/2025 identified Resident #1 was at risk for impaired communication with demonstrated verbal and physical behaviors to express frustration and anger. Interventions directed to allow adequate time for Resident #1 to respond and anticipate needs. An exit seeking risk assessment dated [DATE] identified Resident #1 had no known risk factors for exit seeking behaviors but had disorientation. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was severely cognitively impaired and independent for bed mobility, transfers, and ambulation. A facility reportable event dated 6/11/2025 at 3:06 PM identified a missing resident. Resident #1 was accompanied by NA #1 to a scheduled dental appointment at 11:00 AM. At 3:06 PM, the facility was notified by NA #1 that Resident #1 wandered off and was unable to be located. Resident #1's description of clothes, height and weight were disclosed. Resident #1 was located at 5:30 PM and transported to the hospital emergency department (ED). (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	Interview and review of NA #1's facility interview with NA #1 on 6/16/2025 at 12:15 PM identified she accompanied Resident #1 to a hospital dental appointment (clinic) on 6/11/25. The appointment concluded at 11:30 AM and NA #1 notified the facility to arrange a return ride. She exited the clinic building and sat with Resident #1 on a nearby bench. She received a call around noon to let her know that a problem occurred with return transport arrangements. She continued to wait outside with Resident #1. She identified that Resident #1 used the bathroom twice while waiting and began to stand rather than sit with her on the bench or sat on a wall near her. At 2:30 PM, Resident #1 was about 10 feet away from her by the door to the clinic when she received a call that the return transport ride was 5 minutes away. She turned away from Resident #1 while continuing to talk on the phone and collected her belongings. She hung up and turned back to observe that Resident #1 was no longer in sight. She immediately went inside the clinic to check to see if Resident #1 had gone in alone to use the bathroom again. She determined Resident #1 was not in the bathroom and began to look throughout the lobby area requesting assistance from the clinic security. She contacted the receptionist at the facility at approximately 3:00 PM to report that she could not locate Resident #1. The receptionist reported the information to the Administrator. NA #1 indicated she should not have taken her eyes off Resident #1 as she needed to keep him/her in line of sight at all times. She identified that the ride notification call took longer than she thought and there may have been a total of 5 minutes where Resident #1 was not supervised by her line of sight. She identified she was re-educated by the facility that under no circumstances should a resident be left alone or be outside of the staff's line of sight when they are being escorted to an appointment. Interview with the ADNS on 6/11/2025 at 11:15 AM identified she was with the Administrator when the receptionist reported that NA #1 could not find Resident #1 after a dental appointment at the clinic. The Administrator contacted NA #1 and directed NA #1 to notify the police. The ADNS left to meet NA #1 outside the clinic that was about 15 minutes away by car. When she arrived, the police were on the scene and had begun to search for Resident #1. Staff was mobilized from the facility and other corporate resources/facilities to fan out across the area to search for Resident #1. At 5:30 PM, Resident #1 was found at a gas station (2 miles from the clinic) and was transported to the ED for evaluation. Resident #1 was unharmed and returned to the facility on 6/12/2025. Interview with the DON on 6/16/2025 at 1:05 PM identified NA #1 should have maintained line of sight supervision at all times while out at the appointment with Resident #1 and while waiting for the transportation back to the facility, and the report of not observing Resident #1 for 5 minutes was not appropriate. He continued that NA #1 had since been re-educated. The facility document Rules and Standards for Working Transport Shifts dated 10/15/2019 directed in part, that the staff member who accompanied a resident on an appointment must stay alert and within a close distance to the resident at all times The staff member should not get distracted and should keep the resident in sight at all times. Facility documentation review identified education was initiated on 6/11/2025 for facility staff who have the potential to accompany a dementia residents to appointments within the community. The education included that staff maintained a close proximity to the resident who they are accompanying and that the resident always remained within their line of sight. Education was completed on 6/12/2025. Audits were initiated and a QAPI meeting was held on 6/12/2024. Review identified the facility met the requirements for past non-compliance