STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075296	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ark Healthcare & Rehabilitation at Branford Hills	189 Alps Rd Branford, CT 06405

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41223 Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1), reviewed for wandering, the facility failed to ensure that the family and APRN were notified of an application of a wander guard (security bracelet) due to exit seeking behaviors. The findings include: Resident #1 was admitted with diagnoses that included dementia and status post right hip fracture and malnutrition. An elopement assessment dated [DATE] identified Resident #1 was not an elopement risk and did not make active attempts to leave the facility at the time of the assessment. The 5-day Minimum Data Set (MDS) assessment dated [DATE] identified Resident # 1 had moderately impaired cognition, had no wandering behavior in the prior seven (7) days, and required extensive assistance with one (1) staff for locomotion on the unit and for dressing. The Resident Care Plan (RCP) dated 8/20/2024 identified Resident #1 was at risk for falls, was on anticoagulant therapy and had impaired thought processes. Interventions directed ambulation with rolling walker with assist of 1. A nursing note dated 8/21/2024 at 3:00 PM identified Resident #1 was transferred from the 2nd floor to the third floor with a wander guard in place. A nursing note written by LPN #1, dated 8/25/2024 at 3:25 PM identified increased exit seeking behavior with re-direction ineffective. A note was placed for psychiatric follow up. An APRN #1 (psychiatric) note dated 8/26/2024 identified Resident #1 was seen for increased exit seeking behaviors. Interview and record review with APRN #1 (psychiatric) on 10/1/2024 at 11:42 AM identified she evaluated Resident #1 on 8/26/2024 for the change in behavior of exit seeking and responding aggressively when redirected. Record review failed to identify the physician and Resident #1's family were notified on 8/21/2024 when the wander guard was placed due to exit seeking behavior and the family was not notified on 8/26/2024 with the change in behavior on Resident #1's behaviors. Interview with RN #2 on 10/1/2024 at 10:37 AM identified that she could not recall placing a wander guard on Resident #1. RN #2 stated if she had placed the wander guard, she would have notified the family and the APRN. (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

Printed: 05/28/2025
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075296	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2024

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Ark Healthcare & Rehabilitation at Branford Hills	189 Alps Rd Branford, CT 06405

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Administrator on 10/1/2024 at 12:30PM identified that RN #3, covering supervisor, had placed a wander guard on Resident #1 due to reported increased behaviors by NA #2 and NA #3 on 8/21/2024. The Administrator stated the nurse should have followed the facility process to notify the APRN and family. The Administrator stated she did not know why RN #3 did not follow the facility policy. An interview with RN #3 on 10/1/2024 at 1:15PM identified that she could not recall placing a wanderguard on Resident #1 on 8/21/2024. She continued that if she had it would have been for safety as it is placed on residents when they demonstarte exit seeking behavior. Interview and record review with the DON on 10/2/2024 at 1:10 PM identified that on 8/21/2024 NA #2 and NA #3 reported Resident #1 had exit seeking behavior and RN #3 placed a wander guard. The DON stated the physician and family should have been notified and was unable to explain why they were not notified. The facility policy Change in Resident's Condition dated 5/9/2024 directed in part, that the purpose of the policy was to make resident's physician and resident representative aware of any significant change in resident's condition. A significant change can be in a resident's physical, mental or psychosocial status.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41223 Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1), reviewed for wandering, the facility failed to develop and implement a comprehensive care plan for a resident with known wandering behaviors. The findings include: Resident #1 was admitted with diagnoses that included dementia and status post right hip fracture and malnutrition. An elopement assessment dated [DATE] identified Resident #1 was not an elopement risk and did not make active attempts to leave the facility at the time of the assessment. The 5-day Minimum Data Set (MDS) assessment dated [DATE] identified Resident # 1 had moderately impaired cognition, had no wandering behavior in the prior seven (7) days, and required extensive assistance with one (1) staff for locomotion on the unit and for dressing. The Resident Care Plan (RCP) dated 8/20/2024 identified Resident #1 was at risk for falls, was on anticoagulant therapy and had impaired thought processes. Interventions directed ambulation with rolling walker with assist of 1. A nursing note dated 8/21/2024 at 3:00 PM identified Resident #1 was transferred from the 2nd floor to the third floor with a wander guard in place. A nursing note written by LPN #1, dated 8/25/2024 at 3:25 PM identified increased exit seeking behavior with re-direction ineffective. A note was placed for psychiatric follow up. An APRN #1 (psychiatric) note dated 8/26/2024 identified Resident #1 was seen for increased exit seeking behaviors. A facility reportable event dated 9/8/2024 at 11:24 AM identified a visitor reported they saw a resident in a wheelchair in the driveway. A facility alert was paged, and Resident #1 was located 0.3 miles away from the facility on the side of the road across the street by a pond. The nursing supervisor was notified. The Supervisor took her car to the resident and returned Resident #1 to the facility. No injuries were identified. Interview and record review with APRN #1 (psychiatric) on 10/1/2024 at 11:42 AM identified she evaluated Resident #1 on 8/26/2024 for the change in behavior of exit seeking and responding aggressively when redirected. Record review failed to identify the care plan included the application of the wander guard on 8/21/2024 due to an elopement risk, and the wandering behaviors that were identified on 8/25/2024. Interview with RN #2 on 10/1/2024 at 10:37 AM identified she could not recall placing a wander guard on Resident #1. RN #2 stated if she placed the wander guard, she would have added the wander guard and behavior to the care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and record review with the DON on 10/2/2024 at 1:10 PM identified that on 8/21/2024 NA #2 and NA #3 reported Resident #1 had exit seeking behavior and RN #3 placed a wander guard. Interview failed to identify a care plan was developed to address the wandering behaviors prior to Resident #1's elopement on 9/8/2024. The DON stated RN #3 should have updated Resident #1's care plan and was unable to explain why this was not completed. The DON was unable to explain why nurses working subsequent shifts did not add Resident #1's wandering and exit seeking behaviors in the plan of care, and the care plan should have been updated. The facility Care Planning Policy dated 10/20/2020 directed in part, that a comprehensive and individualized care plan will be developed for each resident. The care plan will guide caregivers to assist residents to achieve or maintain the highest practical level of well-being. The comprehensive care plan identified the needs of residents and is updated as necessary to reflect changes in the resident's status.

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(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 - Immediate jeopardy to resident health or safety 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** 41223 Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1), reviewed for wandering, the facility failed to ensure adequate supervision for a resident with known exit seeking behaviors, to ensure the resident was not able to exit the facility without staff knowledge, and the facility failed to ensure interventions were placed after elopement behaviors were identified. The failures resulted in a finding of Immediate Jeopardy. The findings include: Resident #1 was admitted with diagnoses that included dementia and status post right hip fracture and malnutrition. An elopement assessment dated [DATE] identified Resident #1 was not an elopement risk and did not make active attempts to leave the facility at the time of the assessment. The 5-day Minimum Data Set (MDS) assessment dated [DATE] identified Resident # 1 had moderately impaired cognition, had no wandering behavior in the prior seven (7) days, and required extensive assistance with one (1) staff for locomotion on the unit and for dressing. The Resident Care Plan (RCP) dated 8/20/2024 identified Resident #1 was at risk for falls, was on anticoagulant therapy and had impaired thought processes. Interventions directed ambulation with rolling walker with assist of 1. A nursing note dated 8/21/2024 at 3:00 PM identified Resident #1 was transferred from the 2nd floor to the third floor with a wander guard in place. A nursing note written by LPN #1, dated 8/25/2024 at 3:25 PM identified increased exit seeking behavior with re-direction ineffective. A note was placed for psychiatric follow up. An APRN #1 (psychiatric) note dated 8/26/2024 identified Resident #1 was seen for increased exit seeking behaviors. Ordered Trazodone 25 milligrams every eight hours as needed for anxiety and to monitor for worsening symptoms. A facility reportable event dated 9/8/2024 at 11:24 AM identified a visitor reported they saw a resident in a wheelchair in the driveway. A facility alert was paged, and Resident #1 was located 0.3 miles away from the facility on the side of the road across the street by a pond. The nursing supervisor was notified. The Supervisor took her car to the resident and returned Resident #1 to the facility. No injuries were identified. The facility incident summary dated 9/13/2024 identified Resident #1 had a functioning wander guard in place at approximately 8:00 AM. Resident #1 was last seen on unit at 10:15 AM and was located at 11:42 AM (on the other side of the street approximately 0.3 miles from the facility). The summary further identified Resident #1's wander guard bracelet was located under Resident #1's bed after return to his/her room following the elopment incident on 9/8/24, and Resident #1 stated he/she had cut the bracelet off. Wander guard was reapplied, and Resident #1 was placed on every 15-minute checks. All exit doors were tested , and wander guard system was verified as functioning. (continued on next page)

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview and record review with APRN #1 (psychiatric) on 10/1/2024 at 11:42 AM identified she evaluated Resident #1 on 8/26/2024 for the change in behavior of exit seeking. APRN #1 stated she made recommendations for continued monitoring but did not recommend any increase in monitoring because she was aware Resident #1 had a wander guard in place. Record review failed to identify documentation of an elopement assessment or notification to the family or APRN prior to the 8/21/2024 nursing note that identified Resident #1 had a wander guard placed. Additionally, review failed to identify an RN assessment was completed after increased exit seeking behaviors were noted on 8/25/2024. The medical record also lacked documentation for monitoring placement and function checks of Resident #1's wander guard (security bracelet). Interview with the Administrator on 10/1/2024 at 12:30PM identified RN #3, covering supervisor, had placed a wander guard on Resident #1 due to reported increased behaviors by NA #2 and NA #3 on 8/21/2024. The Administrator stated RN #3 should have followed the facility process to complete an elopement assessment, notify the APRN and family, and enter the placement of the wander guard into the electronic medical record physician order section so that placement would be verified and documented every shift and function verified every day. The Administrator stated she did not know why RN #3 did not follow the facility policy. Receptionist interview on 10/1/2024 at 2:49 PM identified on 9/8/2024 about 8:30 AM, Resident #1 came to the lobby and requested to go outside. The Receptionist stated she knew Resident #1 was an elopement risk and directed Resident #1 to find someone to accompany him/her outside. Occupational therapy (OT #1) interview on 10/1/2024 at 9:55 AM identified on 9/8/2024 at 8:15 AM, Resident #1 entered the therapy department on the 1st floor, and she noticed Resident #1 was not wearing his/her wander guard bracelet. OT #1 stated she had observed RN #2 apply the wander guard bracelet a few weeks prior due to exit seeking behaviors. OT #1 called LPN #2 and notified him that Resident #1 did not have a wander guard in place. Therapy returned Resident #1 to the unit at 10:00 AM after treatment, left Resident #1 with LPN #2 and informed LPN #2 that resident needed a wander guard placed. Interview with RN #2 on 10/1/2024 at 10:37 AM identified that she could not recall placing a wander guard on Resident #1. RN #2 stated if she had placed the wander guard, she would have completed an elopement assessment, notified the family and the APRN, entered orders for wander guard placement checks every shift and function checks daily. Interview with LPN #2 on 10/2/2024 at 10:49 AM identified that therapy returned Resident #1 to the unit at approximately 10:00 AM and indicated the therapist did not tell him a wander guard needed to be placed. He continued that he kept Resident #1 close by to monitor him/her for safety until he left Resident #1 with NA #1 (Resident #1's assigned NA). LPN #2 stated he had observed Resident #1 near the elevators multiple times in the past and had heard the (wander guard) alarms activate. LPN #2 thought this meant Resident #1 was an elopement risk, but he was unaware that Resident #1 had a wander guard in place. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with LPN #1, the nurse caring for Resident #1 on 9/8/2024, on 10/1/2024 at 12:35 PM identified she cared for Resident #1 regularly and identified Resident #1 had a wander guard in place at least since his/her transfer to the unit on 8/21/2024. LPN #1 stated she checked placement of the wander guard on each shift but could not recall why it was not documented, and she had observed Resident #1 multiple times in the past near the elevators and the wander guard alarms would sound. On 9/8/2024, she was told that Resident #1 was found downstairs in the gym but stated she was not informed the wander guard needed to be replaced. She could not recall if she had checked the placement that morning as the computer was down and was passing medications. Interview with NA #1 on 10/1/2024 1:00 PM identified that a wander guard was not in place when she provided morning care on 9/8/2024, and she was unaware Resident # 1 needed a wander guard. She continued that she had observed on previous shifts when Resident #1was near the elevators, alarms would be activated. NA #1 stated she did not know that the alarm would be activated by a wander guard as the only the nurses dealt with that device. Interview and record review with RN #1 (nursing supervisor on 9/8/2024), on 10/1/2024 at 11:50 AM identified at approximately 11:30 AM, the receptionist called her to say a visitor had seen a resident in a wheelchair going down the hill at the end of the driveway. She activated the facility alert and immediately told the staff to check on Resident #1. She identified that when she was working during 9/7/2024 day shift, Resident #1 had dementia, was forgetful, and his/her wander guard had activated the elevator alarm frequently during the shift. RN # 1 stated the wander guard was placed sometime late in August after Resident #1 became self-mobile in the wheelchair and would say he/she was going to his/her apartment. RN #1 stated she worked every weekend, and observed Resident #1 frequently set off the wander guard alarm near the elevators when visitors would complaint that the elevator was not working (the alarm locks the elevators). RN #1 stated when Resident #1 was identified as missing on 9/8/2024, she took her car to search while the receptionist searched the grounds. RN #1 located Resident #1 in a condominium parking lot on the other side of the street approximately 0.3 miles away. Interview and record review with the DON on 10/2/2024 at 1:10 PM identified that on 8/21/2024 NA #2 and NA #3 reported Resident #1 had exit seeking behavior and RN #3 placed a wander guard. Record review failed to identify a physician order entry that directed use of the wander guard, and to check placement and function. The DON stated RN #3 should have entered tracking to ensure placement checks were completed every shift and daily function checks, notify the physician and family, and complete an elopement assessment. The DON was unable to explain why this was not done. Further, the DON stated Resident #1's photo should have been added to the wander guard list located on each unit and at the Receptionist desk. The DON was unable to explain why nurses working subsequent shifts did not add the tracking for placement and function checks, and stated they should have, and was unable to explain why some staff stated they did not know Resident #1 had a wander guard bracelet. The facility investigation identified Resident #1 had cut off his/her wander guard bracelet sometime after 8:15 AM, and the facility identified the roommate gave scissors to Resident #1. The facility policy Elopement Prevention dated 5/9/2024 directed in part, that all residents at risk of elopement should be identified and interventions should be in place for those residents at risk. A photo was taken to add to the wander guard list, the placement of the elopement bracelet (e.g., Wander guard) was verified and documented in the treatment Kardex (TAR) every shift for placement and tested nightly for function. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility documentation review identified education was initiated on 9/8/2024 to include responding to alarms, closing doors, resident photos at the nursing desk and lobby, and elopement evaluation. Audits and QAPI were initiated on 9/8/2024. Additional review failed to identify education included direction to enter tracking for checking wander guard placement every shift, checking wander guard function daily, and communication to staff when a resident requires a wander guard (NA care card). A removal plan was provided by the facility 10/1/2024 at 7:19 PM and accepted by the State Agency. The removal plan included: staff education for elopement risk timing, daily accounting of residents, wanderguard system components, respond to alarms, close doors after egress, wander risk photos in books at the nursing stations and lobby, staff coverage for lobby, and exit seeking behavior interventions. The Plan further included audits and QAPI. Facility documentation review identified staff education was initiated on 9/8/2024 and included review of the elopement policy, assessments, photos in wander risk list on the unit and lobby, orders for monitoring the placement of the wander guard every shift and to check function daily and communicating wander risk residents to staff. Audits were initiated on 9/8/2024, and a QAPI meeting was held on 9/9/2024. Based on review of facility documentation, past non-compliance was identified.