

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075310	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2024
NAME OF PROVIDER OR SUPPLIER Colonial Health & Rehab Center of Plainfield, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 16 Windsor Ave Plainfield, CT 06374	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</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** 44675</p> <p>Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents reviewed for elopement risk, (Resident #1), the facility failed to ensure a resident who was at risk for elopement did not leave the building unsupervised. The findings include:</p> <p>Resident #1 had diagnoses that included severe dementia with agitation, frontotemporal neurocognitive disorder and anxiety.</p> <p>A risk of elopement assessment dated [DATE] identified Patient #1 was at risk for an elopement and a wander guard was in place.</p> <p>The quarterly MDS dated [DATE] identified Resident #1 had severely impaired cognition, was ambulatory with assist, and had one fall with no injury since admission to the facility.</p> <p>A care plan dated 4/9/24 identified Resident #1 was an elopement risk related to disorientation, impaired safety awareness, wanders aimlessly and significantly intrudes on the privacy of others with interventions that included to check the wander guard doors for appropriate settings per protocol, check wander guard function daily, redirect and when the resident was exiting the unit to ask where he/she is going and report exit seeking behavior responses to the charge nurse.</p> <p>A physician's order dated 5/1/24 directed wander guard to left ankle for safety, check placement every shift and to check the function of wander guard device every night shift.</p> <p>Review of the care card dated June 2024 identified Resident #1 was on safety checks every fifteen minutes.</p> <p>A nurse's note dated 6/9/24 at 5:07 PM identified at 4:20 PM Resident #1 was found walking in the parking lot unsupervised. A visitor held the door open and allowed Resident #1 to exit the building. The wander guard did not set off the alarm to the front door. Resident #1 did not leave the property.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An accident and incident form (A & I) dated 6/9/24 identified at 4:20 PM Resident #1 had a wander guard and history of exit seeking behavior. The resident was walking toward the front door when a visitor held the door open and let the resident outside. The wander guard alarm failed to sound, although the wander guard was being checked for function as ordered with no issues identified. Resident #1 had no injuries, the wander guard device was changed and the front doors were subsequently locked.</p> <p>Interview with NA #1 on 6/26/24 at 12:00 PM identified on 6/9/24 she was on her break sitting outside on in the gazebo next to the facility when she looked over at the parking lot and saw Resident #1 walking away from the facility. NA #1 ran over to Resident #1 and was able to re-direct Resident #1 back to the facility. She identified Resident #1 was ambulating independently without any assistive devices, and was fully dressed.</p> <p>Interview with RN #2 on 6/26/24 at 12:11 PM identified she was Resident #1's nurse on 6/9/24 during the 7:00 AM to 3:00 PM shift. Resident #1 had his/her wander guard on during the shift and did not verbalize he/she wanted to leave or exhibit exit seeking behavior during her shift.</p> <p>Interview with NA #2 on 6/26/24 at 12:30 PM identified was one of Resident #1's NA's on 6/9/24 during the 1:30 PM to 9:30 PM shift. She identified Resident #1 was on fifteen-minute checks and last saw him/her a few minutes before the event. She identified when she last saw Resident #1, he/she was in his/her wheelchair in the main hallway that leads to the lobby. She identified it was Resident #1's baseline to wander around the halls, Resident #1 was not observed near an exit during the shift and did not verbalize wanting to leave to her.</p> <p>Interview with RN #1 on 6/26/24 at 12:35 PM identified she was the nursing supervisor on 6/9/24 during the 3:00 PM to 11:00 PM shift. Resident #1 stated h/she wanted to go home and was wandering around the unit per usual. She identified she gave Resident #1 as needed medication for anxiety with fair effect, around 3:00 PM she took the resident for a walk around the inside of the facility. Resident #1 then became tired and went to his/her room and laid down. RN #1 identified about an hour later a family member informed a nurse that Resident #1 was outside, and as RN #1 went to entrance of the facility and observed NA #1 walking Resident #1 back inside the facility. Resident #1 was brought inside and placed on 1:1 at the nursing station, the physician and on call psychiatry services were notified. RN #1 identified that Resident #1's wander guard was checked with the wand and identified it was functioning. She identified when she went to recreate the event, when the front door was closed, the wander guard alarmed, however when the front door was open, the wander guard did not alarm. She further identified the front doors were then locked.</p> <p>Interview with Maintenance on 6/26/24 at 10:50 PM identified that when a resident with a wander guard approaches the door the wander guard system should alarm and lock the front door, then a code entered by staff to silence and re-set the alarm. On 6/14/24 the door was already opened by the visitor, however, the alarm did not sound as it should have when the resident walked out the door. Maintenance checked the front doors and they were functioning appropriately, and the front doors locked and alarmed when a wander guard approached. He identified he contacted the manufacturer they were unsure as to what could have occurred.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Administrator on 6/26/24 at 12:40 PM identified that Resident #1 was on fifteen-minute checks as are all the residents who are at risk for elopement, prior to the event as a facility safety intervention. The wander guard system should have alarmed as the resident exited the building, and was unsure why it did not. The administrator identified subsequent to the event, when there is not a receptionist present, the lobby doors will remain locked with staff assisting visitors in and out of the building. She further identified that wander guard audits began on 6/14/24 to ensure all resident's wander guards were functioning appropriately.</p> <p>Review of the elopement policy and procedure directed that an elopement is the unauthorized leave of a resident without the required supervision necessary to be safe. It continued no staff member observed monitored the elopement take</p>		