

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Essex Meadows Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 30 Bokum Rd Essex, CT 06426	

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** 50059</p> <p>Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of eight (8) sampled residents (Resident #1) who were at risk for elopement, the facility failed to ensure Resident #1, who had exit seeking behaviors and required a wander guard bracelet, was not able to exit the facility unsupervised. The findings include:</p> <p>Resident #1's diagnoses included Alzheimer's, anxiety, restlessness and agitation.</p> <p>A physician's order dated 9/11/24 directed to check the functionality of the wander guard device one (1) time a day and placement of the wander guard on the right ankle every shift.</p> <p>The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had short- and long-term memory deficits, poor decision-making skills regarding tasks of daily life, difficulty focusing attention, and utilized a wheelchair for mobility.</p> <p>The Resident Care Plan dated 10/30/24 identified Resident #1 was an elopement risk related to being forgetful. Interventions directed a wander guard in place, elopement assessments quarterly, and monitor for exit seeking behaviors.</p> <p>A nurse's note dated 11/15/24 at 11:02 PM identified Resident #1 was found by the security guard outside at approximately 10:20 PM in the parking lot. Resident #1 was seated in the wheelchair, fully dressed including a heavy jacket, shoes, and socks, in the parking lot close to the entrance door and security escorted Resident #1 back into the facility. The note identified Resident #1 was wearing the wander guard on the ankle, the alarm did not sound when Resident #1 came through the doors, and the wanderguard was replaced with a new one. The note indicated Resident #1 was assessed and had no ill effects from the incident.</p> <p>Review of the November 2024 Treatment Administration Record identified the function of the wanderguard was last checked on 11/14/24 during the 11PM-7AM shift and placement was checked on the 3-11PM shift on 11/15/24.</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>Interview with the Director of Nursing (DON) on 11/27/24 at 10:00 AM identified the 3-11PM charge nurse called to inform her Resident #1 was found outside after 10:00 PM, sitting in his/her wheelchair, fully dressed and the wander guard was in place. The DON identified staff reported that they did not hear the wanderguard system alarm and Resident #1's wander guard was replaced to ensure proper functioning. The DON stated the wander guard system including residents wander guards are checked daily for appropriate functioning and are replaced if found to not function properly.</p> <p>In an interview with the Director of Plant and Operations on 11/26/24 at 10:43 AM he identified the facility had called him on 11/15/24 after 10:00 PM informing him that Resident #1 was found in the parking lot. The Director of Plant and Operations stated he went to the facility about 11:00 PM to ensure all the doors and exits were retested and working appropriately. The Director of Plant and Operations identified the wander guard doors are tested daily at 3:30 PM by security or maintenance.</p> <p>Interview with the 3-11PM charge nurse, Registered Nurse (RN) #4, on 11/26/24 at 3:15 PM identified she had seen Resident #1 shortly after 9:00 PM and Resident #1 was in his/her room. RN #4 identified she did not hear the wander guard alarm sound, and around 10:00 PM she heard voices coming from the front entrance, where she observed the evening security officer wheeling Resident #1 back into the facility. RN #4 stated she assessed the resident, checked the wander guard and although the wander guard was noted to be working, she changed the wander guard.</p> <p>Review of The Wandering Resident/Monitoring (Wander guard) use dated 11/20/24 policy states any resident determined to be a wanderer with input from the physician, family, or responsible party and the health center team to ensure the residents' safety while maintaining the maximum level of independence.</p>		