STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075351	A. Building B. Wing	12/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abbott Terrace Health Center	44 Abbott Terrace Waterbury, CT 06702

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** 31310 Based on clinical record reviews, facility documentation and interviews for one of three sampled residents (Resident #1) who were independent with ambulation, the facility failed to provide constant supervision during a smoking session to prevent a resident from leaving the facility property unattended. The findings include: Resident #1's diagnoses included Parkinson's disease, abnormalities of gait and mobility and unsteadiness. The wandering/elopement risk evaluation dated 7/31/23 identified Resident #1 was at risk for elopement. The Smoking Evaluation dated 9/22/23 identified Resident #1 required routine supervision during scheduled smoking activity to ensure the resident's safety. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had no cognitive impairment, and required supervision with walking in the room, corridor, on the unit and off the unit. A physician's order dated 10/14/23 directed independent transfers and ambulation without an assistive device, rolling walker as needed. The Resident Care Plan dated 10/26/23 identified Resident #1 wandered, was at risk for elopement and exit seeking behavior related to restlessness as evidence by wandering to exits, attempting to open exit doors. Interventions directed to know Resident #1's whereabouts, determine pattern of wandering, establish routine checks every hour, check the placement of the wander guard every shift and as needed, and check the function of the wander guard per physician order and as needed. The Facility Reported Incident form dated 11/3/23 at 3:05 PM identified Resident #1 exhibited exit seeking behavior and attempted to leave the facility. The nurse's note dated 11/3/23 at 4:00 PM identified Resident #1 was exit seeking and was kept under supervision, safety was maintained and continue to monitor. Upon further review, the nurse's note failed to reflect documentation Resident #1 had left the facility property during the 2:30 PM smoking session. (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	The nurse's note dated 11/3/23 at 9:53 PM identified Resident #1 was kept on one to one (1:1) monitoring this shift due to elopement risk, the wander guard was intact on the right ankle, the aide assisted Resident #1 down to the smoking area to smoke, and no elopement was attempted this shift. Interview with Resident #1 on 12/1/23 at 9:00 AM identified on 11/3/23 during the 2:30 PM smoking break he/she tried to go to a restaurant. Resident #1 indicated Smoking Attendant #1 was watching the residents while smoking, then Smoking Attendant #1 went inside the building and nobody was watching the residents, so he/she left. Resident #1 identified he/she walked about five (5) minutes away from the facility and he/she could not recall the street name he/she was walking on. Resident #1 indicated he/she took a left turn outside the fence of the facility, then another left and then Smoking Attendant #1 caught up with he/she and brought he/she back to the facility. Interview with Smoking Attendant #1 on 12/1/23 at 10:35 AM identified on 11/3/23 he was working as the Smoke Attendant. Smoking Attendant #1 indicated Resident #1 was out for the 2:30 PM smoke break. Smoking Attendant #1 identified as the residents were finishing smoking, he assisted one (1) of the residents back inside the building. Smoking Attendant #1 indicated as he was bringing a resident back to the building another resident was walking towards him and handed him a bag of cigarettes. Smoking Attendant #1 identified he cannot keep unopened packs of cigarettes in the cart, and he had to bring the cigarettes to the security guard located at the entrance to the facility while he had Resident #1 and two (2) other residents finishing smoking in the smoke [NAME] located outside in the back of the facility adjacent to the gated staff parking lot. Smoking Attendant #1 indicated a facility staff member was leaving in the car from the gated parking lot and the gate opened for the car to leave. Smoking Attendant #1 identified as he was walking back to the smoking [NAME] after dropping the cigarettes off, a resident was knocking on the door trying to get someone's attention and stated Resident #1 was leaving, Resident #1 was walking through the gate. Smoking Attendant #1 indicated he ran towards the gate to see how far Resident #1 was, however he could not go through the gate because the gate closed already, so he ran back towards the building and ran through a parking lot of a neighboring business and caught up with Resident #1 about 50 to 100 feet down the street from the facility. Smoking Attendant #1 indicated he had Resident #1 in his eyesight the whole time. Interview with the Director of Nursing (DON) on 12/1/23 at 1:00 PM identified Resident #1 was an elopement risk and a smoker. The DON indicated the procedure was for residents to go to the smoke area, a smoke [NAME] in a group of no more than six (6) residents at a time with one (1) smoking attendant. The DON identified smoking attendants are not allowed to leave any residents back in the smoking [NAME] unattended. The DON indicated the smoking attendants were to wait until all residents had smoked, all were ready and return them to the building. The Smoking policy directed smoking will take place under the supervision of a staff member. The Elopement policy directed the facility strives to promote resident safety by maintaining a process to screen all residents for risk of elopement, implement preventative strategies for those identified at risk, institute measures for resident identification at the time of admission, and conduct missing resident procedures, as warranted. Elopement was defined as the ability of a resident who was not capable of protecting himself or herself from harm to successfully leave the facility unsupervised and unnoticed and who may enter into harm's way.