STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075425	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vanderman Place	595 Valley Street Willimantic, CT 06226

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 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** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #1) who was at risk for elopement , the facility failed to develop an at risk for elopement care plan . The findings include: Resident #1's diagnoses included Parkinson's disease, dementia with behavioral disturbances, adjustment disorder (excessive reactions to stress) and repeated falls. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition and required supervision assistance with transfers and ambulation with a walker. Review of the Elopement Risk Evaluation dated 6/24/24 identified that Resident #1 was at risk for elopement. A nurse's note dated 9/7/24 at 9:21 AM identified that the resident insisted on leaving the facility to attend church and he/she was unable to be redirected. The nurse supervisor followed the resident out the front door, and he/she became 'belligerent' and proceeded down the driveway accompanied by staff. The police were called and when they arrived the resident was agreeable to returning to the facility. A nurse's note dated 9/7/24 at 9:47 AM identified that a Wanderguard was applied to the resident's walker, after being previously removed by the resident. A nurse's note dated 9/9/24 at 3:31 PM identified that the resident once again went out to the front porch unattended and was resistive to the staffs request and redirection to return inside, reporting that staff stayed with the resident, and he/she did eventually return inside but then refused to use the walker. The clinical record lacked any physician's orders for a Wanderguard to be placed to Resident #1 from 6/24/24 through 9/10/24 (please cross reference F 684). A physician's order dated 9/11/24 directed to check for placement of the Wanderguard to the left shoe every shift and to check the function of the device daily on the 11:00 PM to 7:00 AM shift. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 9/18/24 directed to check for placement of the Wanderguard in the tennis ball on the foot of the walker every shift and to check the function of the device daily on the 11:00 PM to 7:00 AM shift. A nurse's note dated 10/4/24 at 7:12 PM identified that the resident was agitated and running down the hallway without his/her walker. The resident became upset and was yelling and swearing at the staff and insisted that he/she was leaving. The police were called and were able to calm the resident down. A nurse's note dated 10/5/24 at 5:20 PM identified that at 5:00 PM, the resident stated he/she was going outside, refused the walker and was unable to be redirected, The note identified that he/she then 'burst open' the door on the second wing and a male staff accompanied him/her to sit in the sun. A nurse's note dated 10/23/24 at 11:58 AM identified that the resident took off down the driveway towards the street. Staff attempted to encourage the resident to return back inside the facility, but the resident was unable to be redirected and became aggressive, swinging at the staff. The police were called for assistance. A Psychiatric Emergency Certificate (PEC, a document used for psychiatirc emergencies) was initiated, and the resident was transported to the hospital. Interview with the DNS on 12/11/24 at 11:58 AM identified that the resident had exited through both the front entrance and the emergency exits throughout his stay at the facility, most recently on 9/7/24, 10/5/24 and 10/23/24, however was accompanied by staff. She identified that the resident did not have an at risk for elopement care plan and should have, since the elopement assessment on 6/24/24 identified that the resident was at risk for elopement. Review of the Person Centered Care plan policy identified that care plans will contain the necessary information to properly care for the resident. Review of the Wanderguard policy dated 12/6/21 directed, in part, that the resident will be evaluated to determine if they are at risk for wandering out of the facility. Should the resident be deemed at risk for wandering out of the facility, a physician's order will be obtained to have the Wanderguard applied, the care plan and care card will be updated to reflect the use of the device. The resident's Wanderguard will be checked every shift for placement and will be checked for function every 11-7 shift. Wanderguard placement and function checks will be documented on the [NAME].

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for elopement, the facility failed to obtain a physician's order timely for a Wanderguard to be placed after the resident was identified as at risk for elopement and failed to ensure that staff was monitoring the placement and functionality of the Wanderguard in accordance with facility policy. The findings include: Resident #1's diagnoses included Parkinson's disease, dementia with behavioral disturbances, adjustment disorder (excessive reactions to stress) and repeated falls. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition and required supervision assistance with transfers and ambulation with a walker. Review of the Elopement Risk Evaluation dated 6/24/24 identified that Resident #1 was at risk for elopement. There was no care plan for elopement risk (please reference F 656). A nurse's note dated 9/7/24 at 9:21 AM identified that the resident insisted on leaving the facility to attend church and he/she was unable to be redirected. The nurse supervisor followed the resident out the front door, and he/she became 'belligerent' and proceeded down the driveway accompanied by staff. The police were called and when they arrived the resident was agreeable to returning to the facility. A nurse's note dated 9/7/24 at 9:47 AM identified that a Wanderguard was applied to the resident's walker, after being previously removed by the resident. A physician's order dated 9/11/24 directed to check placement of the Wanderguard to the left shoe every shift and to check the function of the device daily on the 11:00 PM to 7:00 AM shift. The clinical record lacked any documentation or physician's orders for a Wanderguard, and to check for placement and functionality from 6/24/24 (when the elopement assessment identified a wander risk) through 9/10/24. Interview with the ADNS on 12/19/24 at 11:29 AM identified that the resident was identified as at risk for elopement on admission on [DATE]. The ADNS identified that while looking through the clinical record she located an order for the Wanderguard to be placed to Resident #1 on 7/29/24, however, the order did not specify the location of the Wanderguard, and it did not carry over to the Treatment Administration Record (TAR) for the nurses to ensure the placement and functionality of the Wanderguard. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Wanderguard policy dated 12/6/21 directed, in part, that the resident will be evaluated to determine if they are at risk for wandering out of the facility. Should the resident be deemed at risk for wandering out of the facility, a physician's order will be obtained to have the Wanderguard applied, the care plan and care card will be updated to reflect the use of the device. The resident's Wanderguard will be checked every shift for placement and will be checked for function every 11-7 shift. Wanderguard placement and function checks will be documented on the [NAME].

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and interviews for one (1) of three (3) residents (Resident #4) reviewed for a room change, the facility failed to ensure a room change was documented and social service support was provided regarding a room change. The findings include: Resident #4's diagnoses included major depressive disorder and conversion disorder (mental health issues causing physical symptoms). The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition and was independent with bed mobility and required moderate assistance for transfers and ambulation. Review of the facility census identified that Resident #4 was admitted to the facility on [DATE] and his/her room was changed on 1/17/23. A nurse's note dated 1/17/23 at 4:34 AM identified that Resident #4 expressed agitation with the roommate's behaviors of blasting music and television during the night. A voice message was left for social services. A nurse's note dated 1/18/23 at 4:02 AM identified that Resident #4 was adjusting to new room and roommate. Review of social service notes for January 2023 failed to identify any documentation until 1/26/23, which did not note a room change had occurred. Interview with Social Worker #1 on 12/11/24 at 2:16 PM identified that although she was not employed by the facility in 2023, social services is responsible for handling all room changes, including touring potential new rooms for residents and their families, getting approval from the resident representative if applicable, documenting on the initial room change and then following-up with the resident for two (2) days after the room change to ensure the resident is adjusting well to their new environment. She identified that all encounters are to be documented in the clinical record, and she was unsure why Resident #4's room had been changed and there was no documentation from social services in the clinical record. Interview with the DNS on 12/11/24 at 2:32 PM identified that social services is responsible for the coordination of all room changes including communication to families regarding the room change, following up with the resident for 2-days following the room change and documentation in the clinical record. She identified that anytime that there's communicated issues with a resident's roommate, they do their best to accommodate a change as early as possible and was unsure what had transpired with Resident #4 or who changed the resident's room on 1/17/24. Review of the Transfer, Room to Room policy dated 12/2016 directed, in part, that the following information should be recorded in the resident's medical record: The date and time the room transfer was made, the name and title of the individual who assisted in the move, all assessment data obtained during the move and how the resident tolerated the move.