

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195464	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER The Ellington		STREET ADDRESS, CITY, STATE, ZIP CODE 308 Amelia Street Rayne, LA 70578	

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 - Immediate jeopardy to resident health or safety</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** 47540</p> <p>Based on record reviews, observations, and interviews, the facility failed to implement care plan interventions and provide adequate supervision to ensure a cognitively impaired resident, who had a history of wandering did not elope for 1 (Resident #1) out of 3 sampled resident (Resident #1, #2, and #3).</p> <p>This deficient practice resulted in an Immediate Jeopardy on 08/23/2024 at 6:51 p.m. when Resident #1, a severely cognitively impaired resident, was unsupervised and eloped from the facility. On 08/23/2024 beginning at 5:10 p.m., Resident #1 was observed by multiple staff members repeatedly attempting to open several doors throughout the facility before exiting the facility's front entrance door undetected by staff at 6:51 p.m. On 08/23/2024 at 7:03 p.m., the facility received a call from a citizen that observed the resident in a residential area approximately 300 feet away from the facility. Resident #1 was brought back to the facility by staff at 7:10 p.m. Resident #1 was transferred to another facility with a secured unit on 08/28/2024.</p> <p>This deficient practice placed one resident that remained in the facility, who had been assessed as having wandering behaviors, at risk for undetected elopement.</p> <p>S1ADM (Administrator), S2DON (Director of Nursing), and S3ADON (Assistant Director of Nursing) were notified of the Immediate Jeopardy on 09/04/2024 at 2:00 p.m.</p> <p>The Immediate Jeopardy was removed on 09/04/2024 at 5:30 p.m., as confirmed by onsite verification through observations, interviews, and record reviews the facility implemented an acceptable Plan of Removal (POR) prior to the survey exit.</p> <p>Findings:</p> <p>Review of Resident #1's record revealed he was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Dementia with Other Behavioral Disturbance, Bipolar Disorder, Repeated Falls, Unsteadiness on Feet, and Other Lack of Coordination.</p> <p>Review of Resident #1's Quarterly MDS (Minimum Data Set) dated 07/17/2024 revealed the BIMS (Brief Interview for Mental Status) of 5, indicating his cognition was severely impaired. Under Section P: Restraints and Alarms revealed the resident had a wander/elopement alarms used daily.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195464	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER The Ellington		STREET ADDRESS, CITY, STATE, ZIP CODE 308 Amelia Street Rayne, LA 70578	
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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident Resident #1's current comprehensive plan of care with a target date of 05/21/2024, revealed Resident #1 was an elopement risk/wanderer; initiated on 05/21/2024. Interventions created on 05/21/2024 included in part . Distract resident from wandering . by offering pleasant diversions, structured activities, food, conversation, television, book . Identify pattern of wandering prn: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. Monitor locations as needed.</p> <p>Review of Resident #1's physician's orders revealed an order with a start date of 06/24/2024 read in part, Monitor elopement alarm bracelet to right ankle every shift.</p> <p>Review of Resident #1's Elopement Evaluation dated 06/24/2024 revealed in part:</p> <p>Elopement Score: 1.0 (At Risk)</p> <p>BIMS Score: 5</p> <p>Has the resident verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door? Yes</p> <p>Abnormalities: Verbally expressed desire to go home, packed belongings to go home or stayed near an exit door</p> <p>Clinical Suggestions: Apply personal safety alarm device, Monitor location frequently, and Notify staff of elopement risk.</p> <p>Review of Resident #1's Progress Notes revealed the following:</p> <p>07/03/2024 at 12:15 p.m., by S4LPN (Licensed Practical Nurse), .Resident trying to open door to leave to go meet his wife .</p> <p>07/15/2024 at 10:13 a.m., by S4LPN, .Resident away from station pushing on the door.</p> <p>07/30/2024 at 6:39 a.m., by S4LPN, .Resident ask to open the door so he can go home multiple times. Explained to resident multiple times I cannot open the door and he lives here now. Resident says no and pushes on the door. Unable to redirect resident .</p> <p>Review Resident #1's Incident Report completed on 08/23/2024 at 9:23 p.m. by S5LPN, read in part . 7:02 pm received a call from neighbors across the street from the facility stating that resident was down .street. This nurse as well as all staff members around when the call came in rushed outside the facility. Resident was down (street) near the house before the intersection . were able to get the resident back into the facility, elopement alarm bracelet present on resident . Predisposing Situation Factors: active exit seeker and wanderer were checked .</p> <p>Review of Witness Statement completed on 08/23/2024 by S6LPN, revealed the following . Last time I seen Resident #1 he was wandering the hallways of Hall W going to Hall W's west side back door trying to open it, when it didn't open he turned around and went another direction.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195464	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER The Ellington		STREET ADDRESS, CITY, STATE, ZIP CODE 308 Amelia Street Rayne, LA 70578	
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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Witness Statement completed on 08/23/2024 by S6LPN, revealed the following . Last time I saw resident was at the door by the nurse's station trying to get out. Then when another resident told him the doors were locked; he went down the hall toward the dining room.</p> <p>Review of Witness Statement completed on 08/23/2024 by S7Laun (Laundry Staff), read in part .Last time was when the medicine man was here Resident #1 was at the back door, I told the man to hide on the side of the breakroom until Resident #1 passes then Resident #1 left .</p> <p>Review of the facility's video surveillance on 09/03/024 at 1:15 p.m. with S2DON, revealed on 08/23/2024 at 5:10 p.m., Resident #1 was sitting in his wheelchair pushing on the exit door in the dining room. On 08/23/2024 between 5:13 p.m. - 6:32 p.m. Resident #1 was observed pushing on three different exit doors on Hall W. He was observed pushing on each door more than once every few minutes. Multiple staff members were visible in the facility's video surveillance who observed Resident #1 push on different exit doors on the Hall W. No staff members on video surveillance approached the resident to redirect or distract the resident from pushing on the doors. On 08/23/2024 at 6:36 p.m., Resident #1 was seen pushing on the back entrance door. Between 6:37 p.m. - 6:46 p.m. Resident #1 was observed going back and forth between the front lobby entrance door and back entrance door every few minutes. At 6:48 p.m. Resident #1 was seen on video surveillance pushing on the back entrance door. During this time, S7Laun came out of the laundry room and watched the resident push on the back entrance door. On the video surveillance, S7Laun had not approached the resident and was seen going back into the laundry room. At 6:51:05 p.m., Resident #1 was seen at the front lobby door attempting to push on the door with his hands and ramming his wheelchair into the door. At 6:51:23, the front lobby door opened and Resident #1 eloped from the facility. On the facility's video surveillance, no staff was observed near the front lobby door during any of the times Resident #1 was seen pushing on the door.</p> <p>On 09/03/2024 at 11:00 a.m., an interview was conducted with S6LPN. S6LPN stated she worked on the Hall W the evening Resident #1 eloped from the facility. She stated she observed him at approximately 6:15 p.m. trying to push open the exit doors several times on the Hall W and wander around the facility. She confirmed she never attempted to intervene by redirecting or distracting the resident when he was pushing on the exit doors and had not notified S5LPN, his assigned nurse, of the exit seeking behaviors Resident #1 had displayed. She confirmed she had not any heard alarm the evening of 08/23/2024 when Resident #1 eloped from the facility.</p> <p>Multiple attempts were made to contact S5LPN via phone on 09/03/2024 at 11:17 a.m., at 11:48 a.m., 12:25 p.m. and at 2:14 p.m. S5LPN failed to return any phone calls and was unable to be interviewed.</p> <p>On 09/04/2024 at 2:29 p.m., an interview was conducted with S7Laun. She stated on the evening of 08/23/2024 she worked in the laundry room which was on the same hall as the back entrance door. She confirmed that she had observed Resident #1 at the back entrance door trying to push it open and had not approached the resident to try to redirect him and had not notified his nurse.</p> <p>On 09/03/2024 at 3:17 p.m., an elopement alarm bracelet was tested at the front lobby door with S2DON. The alarm activated when the elopement alarm bracelet was approximately 10 feet away from the front lobby door and upon demonstration the front lobby door alarm's volume was very faint.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195464	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER The Ellington		STREET ADDRESS, CITY, STATE, ZIP CODE 308 Amelia Street Rayne, LA 70578	
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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 09/03/2024 at 4:10 p.m., an interview was conducted with S2DON. S2DON stated that in June 2024 an elopement alarm bracelet was applied on the resident due to exit seeking behavior such as Resident #1 telling multiple staff members that he wanted to go home. She stated that in July 2024 he had multiple exit seeking behaviors by pushing on the exit doors several times throughout the day. She stated on 08/23/2024, when the resident was displaying exit seeking behaviors on the Hall W, the staff could have redirected him. However, he would have went back to repeating the same behavior because that was normal for him. She stated the facility relied on all the elopement alarm and locking mechanism located on the front lobby door and back entrance door that activated when a resident with an elopement alarm bracelet was nearby. She stated there was no explanation or reasoning of why Resident #1 eloped from the facility other than the front lobby door possibly glitched when Resident #1 pushed on the door and pushed his wheelchair in the door which caused it to open.</p> <p>On 09/04/2024 beginning at 8:33 a.m., the elopement alarm bracelet volume was tested near the front lobby door:</p> <ol style="list-style-type: none"> On 09/04/2024 at 8:33 a.m., an interview was conducted with S6LPN on Hall W's nurse's station approximately 100 feet away from the front lobby door. The front lobby door alarm was activated. S6LPN confirmed that she could not hear the alarm. On 09/04/2024 at 8:35 a.m. the front lobby door alarm was activated. Observation made of S2DON sitting in her office with the office door open. Her office was located approximately 90 feet away from the front lobby door. S2DON did not respond to the elopement alarm bracelet. On 09/04/2024 at 8:38 a.m., an interview was conducted with S8CNACoor (Certified Nursing Assistant Coordinator) on Hall X's nurse's station located approximately 111 feet away from the front lobby door. The front lobby door alarm was activated. S8CNACoor confirmed that she could not hear the alarm. On 09/04/2024 at 9:31 a.m., an interview was conducted with S1ADM near an exit door on Hall W located approximately 130 feet away from the front lobby door. The front lobby door alarm was activated. S1ADM confirmed that he could not hear the alarm. On 09/04/2024 at 9:35 p.m. the front lobby door alarm was activated. The farthest the alarm could be heard was approximately 53 feet away near the beauty salon. <p>On 09/04/2024 at 10:52 a.m., an interview was conducted with S9LaunSup (Laundry Supervisor). She stated the laundry room was on the same hall as the back entrance door and if a resident with an elopement alarm bracelet goes near the door the alarm activated and she expected laundry staff to check on the alarm and respond. She stated if the alarm was activated due to a resident with an elopement alarm bracelet being near the back door then laundry staff should have checked on the resident, persuaded them to turn around away from the door, and bring the resident to their nurse and notify them of what their resident was doing.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195464	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER The Ellington		STREET ADDRESS, CITY, STATE, ZIP CODE 308 Amelia Street Rayne, LA 70578	
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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 09/04/2024 at 4:33 p.m., an interview was conducted with S1ADM. S1Admin stated Resident #1 was readmitted back to the facility in May 2024 and throughout his stay he could tell that the resident did not want to be here. The resident always walked around the facility and showed exit seeking behavior such as telling the staff he wanted to go home to his wife. An elopement alarm bracelet was applied after the resident displayed these behaviors. S1ADM stated he had observed Resident #1 pushing on exit doors numerous times. S1ADM confirmed that nursing staff should have attempted to redirect Resident #1 when they saw him pushing on the exit doors down the Hall W several times on 08/23/2024. He confirmed when laundry staff observed Resident #1 pushing on the back entrance door she should have intervened and got that resident's LPN. He stated staff relied on the elopement alarm bracelet lock mechanism on doors to prevent elopement. He confirmed Resident #1 left the building and the facility's premises undetected by staff. He confirmed the front lobby door was not monitored by staff to prevent Resident #1's elopement.</p>		