

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215329	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Buckingham's Choice		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Baker Circle Adamstown, MD 21710	

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>50502</p> <p>Based on review of the facility investigation, record review, observation and interview. It was determined that the facility failed to provide a safe environment to prevent an elopement incident from occurring. This was evident for 1 (Resident # 231) of 2 residents reviewed for elopement during the survey.</p> <p>The findings include:</p> <p>Wander guard is a wandering management system that monitors residents using a wearable bracelet. The system relies on three components: bracelets that residents wear, sensors that monitor doors, and a technology platform that sends real-time safety alerts. When a resident with a bracelet approaches a monitored door, the system alerts.</p> <p>On 11/21/24 at 5:30 PM, the surveyor reviewed Facility Self-Reported incident MD00190943. The review revealed that Resident #231 had an elopement incident on 4/4/23. The facility's interview with Licensed Practical Nurse (LPN #1) revealed that the door alarm sounded at 7:27 PM and upon assessment, he/she observed a family member entered the unit. Resident #231 could not be found in his/her room. While LPN #1 was contacting the campus security, he/she was informed by the security that Resident #231 was observed walking outside on the facility campus at approximately 7:31pm. As Resident #231 was walking towards campus security, he/she had a fall and sustained a minor skin tear to his/her right eyebrow. First aide was provided by LPN #1. Resident #231 was assessed and escorted safely back to the unit.</p> <p>Further review of the elopement investigation revealed the following interventions that were put in place after the incident:</p> <ul style="list-style-type: none"> - The resident was assessed (including neuro checks) and escorted back to the room. - The resident representative was updated - Physician was notified - 1 on 1 sitter for 48 hours was initiated - Wander guard checked <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>	<ul style="list-style-type: none"> - Signage was posted as a reminder to visitors to keep the door secure and closed behind them when entering and exiting the unit - 6 staff members were interviewed - Door alarms and wander guard system were tested - Inservice was conducted on: 4/20/23, Elopement training and drill code silver, attended by 42 staff members - Elopement drill was conducted on 5/24/22, which was attended by 18 staff members. <p>On 11/21/24 at 5:00 PM, a review of Resident #231's medical record revealed a BIMS score of 99.0 on 3/31/2021 (Resident is rarely/never understood). Brief Interview for Mental Status (BIMS) is a screening tool used to assess basic cognitive function in patients in long-term care facilities. A BIMS score of 99 signifies that the BIMS assessment was not able to be finished due to the patient's inability to engage or provide adequate answers. An elopement assessment was conducted on 3/29/24 with a score of 6 which meant at risk to wander. Another elopement assessment was performed on 4/1/23 with a score of 17 which meant a high risk to wander. A wander alert device was then added as an intervention and checked for function and placement regularly.</p> <p>On 11/22/24 at 8:25 AM, in an interview with the Director of Nursing (DON) she stated that Resident #231 used the door located on the left side when exiting the skilled unit double doors. She added that the door was not part of the skilled unit and had no lock. Based on another surveyor's observation, the unmanned double doors of the skilled unit were approximately 15 steps from the unlocked door that lead to outside premises.</p> <p>On 11/22/24 at 8:37 AM, the DON performed a wander guard system test with the surveyors. The DON walked with the wander guard towards the double doors that were opened, and the alarm went off. Again, the DON walked with the wander guard but this time the double doors were closed, the doors locked but did not alarm. The DON explained that the double doors would alarm if a resident with a wander guard passed through the double doors that had been opened, such as when a staff or visitor exited/entered the unit. If a resident with a wander guard walked near the double doors that were closed, a clicking sound would be heard which meant the doors locked and wouldn't alarm.</p> <p>On 11/22/24 at 8:51 AM, in an interview with Staff #12, he/she stated that the facility had used the wander guard system for 4-5 years. He/she added if a resident had a wander guard and walked near the double doors, the doors wouldn't open unless the code was entered, or someone opened the doors. He/she stated that the door located on the left side leading to the Independent Living (IL) when exiting the double doors, locked from outside but not from the inside.</p> <p>On 11/22/24 at 9:47 AM, during an interview LPN #1, he/she narrated to the surveyors that on 4/4/2023, he/she heard the alarm and looked for Resident #231, he/she ran to the door and saw family members walking out and said they saw the resident, other staff members also looked for the resident. He/she stated that Resident #231 was found near the entrance by the security area and added that the alarm system alerted the nurses' pager with the resident's identifier number.</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>On 11/22/24 at 9:54 AM, an interview with the DON revealed that they learned that Resident #231 was missing when LPN #1 stated that visitors walked down the hallway and assumed that the resident went with them. However, based on the initial facility investigation, LPN #1 stated that he/she observed a family member entered the unit.</p> <p>On 11/22/24 at 11:26 AM, the DON and the Regional Clinical Director were notified of the surveyor's concern that the facility failed to prevent the elopement incident. They enumerated a few interventions that were put in place for the current residents who wandered and were at risk for elopement: random audits, elopement committee meetings, frequent residents' assessments and behavior monitoring.</p> <p>On 11/22/24 at 11:55 AM, the DON stated that the facility added an intervention on 11/22/24: double doors automatically closed from 6:00 PM to 8:00 AM. Anyone who wanted to get in the skilled unit will have to call the number indicated on the signage.</p>		