STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225466	A. Building B. Wing	07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highview of Northampton	222 River Road Leeds, MA 01053

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. 48138 Based on records reviewed and interviews for one of three sampled residents (Resident #1), who resides on a locked unit (with front and rear entrance/exit alarmed doors), was cognitively impaired, was assessed and care planned by nursing due to his/her increased risk for elopement, the Facility failed to ensure he/she was provided an adequate level of staff supervision to prevent an incident of elopement, when on 06/19/24, Resident #1 was able to open the units' rear exit door, no alarms sounded due to a malfunctioning door alarm system, he/she was able to exit the unit and the facility undetected by staff and was found outside. Findings include: Review of the Facility Policy titled, Elopement, dated July 2015, indicated that the Facility strives to promote resident safety. The Policy further indicated the following; -an elopement is defined as the ability of a resident who is not capable of protecting himself or herself from harm to successfully leave the facility unsupervised and unnoticed and who may enter harm's way. Review of the Report submitted by the facility via the Health Care Facility Reporting System (HCFRS), dated 06/19/24, indicated Resident #1 was found outside by a staff member and the unit staff and security were unaware he/she had left the building. Further review of the Report indicated Resident #1 was last seen by staff on the unit around 10:50 A.M., was found outside (alone) at 11:30 A.M., by a staff member and had been outside (unescorted by a staff member) for approximately 40 minutes (unbeknownst to staff). Resident #1 was admitted to the Facility in April 2019, diagnoses include, alcohol induced dementia, cognitive communication deficit related to encephalopathy (the presence of neurological symptoms caused by biochemical lesions of the central nervous system), diabetes mellitus and atrial fibrillation. Review of Resident #1's Nursing Elopement and Wandering Assessment, dated 1/03/24, indicated he/she was assessed as being at increased risk for elopement and required an Elopement/Wandering Care Plan. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 06/12/24, indicated he/she scored a 3 out of 15 on his/her Brief Interview for Mental Status (BIMS) Assessment (0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired cognition, and 12-15 suggests a resident is cognitively intact). The MDS, Section GG (baseline mobility) indicated Resident #1 was independent with ambulation. Review of Resident #1's Care Plan, renewed and reviewed with his/her June 2024 MDS, indicated nursing staff had developed care plans secondary to impaired cognition, and that he/she had been identified as a wanderer and an elopement risk. During a telephone interview on 07/11/24 at 11:42 A.M., the Assistant Director of Activities, said on 6/19/24, around 11:30 A.M., that she found Resident #1 outside of the building in the parking lot and he/she told her that he/she pressed on the back door of the unit and went outside. The Assistant Director of Activities said Resident #1 had behaviors of wandering and that he/she tended to want to go outside with the smoking group even though he/she was not a smoker. During an interview on 07/09/24 at 1:34 P.M., Certified Nurse Aide (CNA) #1 said that Resident #1 ambulated independently on the unit, that he/she liked to walk up and down the hallway, had a history of pushing on the exit doors to try to go out. CNA #1 said Resident #1 liked to go outside. During an interview on 07/09/24 at 2:12 P.M., Nurse #1 said Resident #1 did a lot of walking up and down the unit hallway, and would look out the windows and the doors on his/her unit. Nurse #1 said on the day of the incident, the Security Guard that was in place on the unit due to malfunctioning door alarms did not tell her he was leaving his station (seated outside front door of unit) and going on rounds. Nurse #1 said the Security Guard always told a staff member on the unit when he left to do round, but did not know who the Security Guard notified that day. During an interview on 07/09/24 at 11:40 A.M., the Security Guard said he was stationed at the front door of the unit, on the outside of the door, and could visually see the back exit door of the unit. The Security Guard said when he does rounds, he notifies a staff member, but said he was unable to say which staff member he had notified. The Security Guard said he was unable to provide any sort of documentation, like a shift report log, to support that when he leaves his station to do rounds, who he reported off to on the Unit to ensure staff were aware and therefore monitored the Unit while completing his security rounds, and said he they do not track that information. During an interview on 07/09/24 at 2:00 P.M., the Administrator said a Security Guard was stationed outside the entrance door to the unit and was able to monitor both front and back doors. The Administrator said the Security Guards also had to perform security rounds around the facility throughout the day and that the Security Guards would alert the staff on the unit when going on rounds. The Administrator said that it is the Facility's expectation that the staff on the unit monitor the exits while the Security Guard was away from his/her post. .