STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225584	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Avenue Health Center	146 Park Avenue Arlington, MA 02174

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 43963 Based on records reviewed, interviews and observations for one of six sampled residents (Resident #1), the Facility failed to ensure they provided an adequate level of staff supervision to prevent an incident of elopement, resulting in injuries. 1) On 11/02/24, Resident #1 who had severe cognitive impaired, and was assessed as being at increased risk for elopement, exhibited increased exit seeking behaviors including making multiple attempts to leave the Facility through alarmed exit doors on the unit, asked staff members for a ride home and required constant redirection by staff. Sometime before lunch, Resident #1 was redirected by a staff member to go to an activity going on in the day room. However, that was the last time staff recall seeing Resident #1, and it was not until staff noticed that his/her lunch tray was untouched that staff determined he/she was no longer in the Facility. Resident #1 was found the next day at a convenience store located in the next town (3.6 miles away from the Facility). Resident #1 was transferred to the Hospital Emergency Department for evaluation, was noted to have cuts to the back of both his/her hands and feet, abnormal blood laboratory work, bruises and was admitted . 2) The Facility also failed to ensure that the fenced in patio area located just off the day room utilized by residents for smoking and/or outside activities was secured, so that residents at risk for elopement could not easily access the area unsupervised. Per the facility a designated staff member must enter a security code in the keypad to unlock the patio door to let residents out to smoke, the staff member must stay outside to supervise the smoking group and use the code again to open to door to escort the residents back into the building. However, on 11/15/24, during the survey, multiple residents were observed entering the keypad code number by themselves and exit the day room to go out to the patio area to smoke. During the observation, there were no staff members present in the day room or out on the patio to provide supervision. It was also observed that one of the gates out on the patio that led to the facility parking lot was wide open, and unsecured, therefore making it easy for any resident to elope undetected. Findings include: Review of the Facility's Policy titled Safety and Supervision of Residents, dated as last revised 07/2017, indicated that the Facility strives to make the environment as free from accident hazards as possible and safety, supervision, and assistance to prevent accidents are a facility-wide priority. The Policy further indicated the following; (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: 225584	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

-Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting process;

-Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards;

-The facility-oriented and resident-oriented approaches to safety are used together implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors; and

-Resident supervision is a core component of the systems approach to safety.

1) Review of the Report submitted by the Facility via the Health Care Facility Reporting system (HCFRS), dated as submitted 11/08/24, indicated that on 11/02/24 at approximately 11:50 A.M., Resident #1 was unable to be located despite searching his/her room, unit, Facility (both inside and out) and surrounding neighborhoods.

Resident #1 was admitted to the Facility in October 2024, diagnoses included metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood), alcohol abuse, polysubstance abuse, acute Pulmonary Embolism (PE, blood clot located in the lungs), Deep Vein Thrombosis (DVT, blood clots) to both lower extremities and bipolar disorder.

Resident #1's Hospital Discharge Summary, dated 10/31/24, included progress notes related to poor safety awareness and exit seeking behaviors exhibited by him/her while in the hospital, with the need for additional safety measures that were implemented during his/her admission, as follows:

-Hospital Physical Therapy Progress Note, dated 10/24/24, indicated he/she required one to one (1:1) continuous monitoring for safety.

- Hospital Nurse Progress Notes, dated 10/24/24 and 10/25/24, indicated he/she required a 1:1 sitter and a bed alarm for safety.

- Hospital Nurse Progress Note, dated 10/27/24, indicated that a Code Gray (missing person) was called due to Resident #1 trying to leave.

-Hospital Nurse Progress Note, dated 10/28/24, indicated he/she required a 1:1 sitter and a bed alarm for safety.

Review of Resident #1's Brief Interview Mental Status (BIMS), dated 11/01/24, indicated he/she scored a 4, indicating he/she was severely cognitively impaired (0-7 indicated severe cognitive impairment, 8-12 indicates moderate cognitive impairment, and 13-15 indicates intact cognition).

Review of Resident #1's Nurse Progress Note, dated 11/01/24 at 1:09 P.M., indicated that he/she was experiencing increased agitation, increased mood and increased pacing.

Review of Resident #1's Care Plan titled Wandering, dated 11/01/24, indicated he/she was at risk for wandering related to his/her impaired cognition.

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/14/24 at 12:27 P.M., the Activity Assistant said that on 11/01/24 at approximately 10:45 A.M., she was conducting a group activity (playing trivia and other games) in the day room and Resident #1 was one of five (5) residents in attendance. The Activity Assistant said that two residents entered the day room and asked her if they could go out to smoke (the designated smoking area entrance/exit is in that day room) and said she let the smokers out into the designated smoking area by entering the code into the keypad that releases the door. The Activity Assistant said when she went to let the two residents back inside, Resident #1 followed her to the door, he/she went out onto the patio and when she asked him/her to go back inside through the day room door to the activity table, Resident #1 refused and said no. The Activity Assistant said she remained with Resident #1, that they walked around the building and entered again through the front entrance door to the Facility. The Activity Assistant said she had texted a staff member to meet her at the front entrance to help encourage Resident #1 to go back inside the building. Review of Resident #1's Elopement/Exit Seeking Evaluation, dated 11/01/24, (completed after the incident with the Activity Assistant) indicated he/she was at an increased risk for elopement. During a telephone interview on 11/27/24 at 9:22 A.M., Certified Nurse Aide (CNA) #3 said that on 11/02/24, there were three CNA's working the day shift on Unit 2 (Resident #1's unit) and she was floating back and forth between the two sides of the unit (upper and lower side). CNA #3 said just as she was getting to work at 7:00 A.M., she noticed Resident #1 pacing back and forth on the unit, that he/she appeared very confused, disoriented and was asking to go home. CNA #3 said that she last saw Resident #1 while she was assisting another resident with care in the room directly next to the alarmed exit door on the second floor. CNA #3 said she could hear someone trying to open the exit door so she went to see who it was. CNA #3 said she saw Resident #1 at the door, asked Resident #1 what he/she was doing and that he/she said he/she was just looking outside. CNA #3 said that she redirected Resident #1 away from the exit door, walked him/her down the hallway back towards the opposite direction on the unit and returned to her assignment. During an interview on 11/14/24 at 12:43 P.M., Certified Nurse Aide (CNA) #1 said on 11/02/24 she worked the 7:00 A.M. to 3:00 P.M., shift on Unit #2, which is split up into lower and upper sides, that she was assigned to work on the side of the unit where Resident #1 resided and that he/she was on her assignment. CNA #1 said Resident #1 had already been dressed in regular street clothes at the start of the shift. CNA #1 said starting around 7:30 A.M., Resident #1 continuously asked her and Nurse #1 for a ride home. CNA #1 said that she had been in another room providing care to a different resident and said she could hear someone trying to push through the exit door at the end of the hall. CNA #1 said she went to check it out, saw Resident #1 at the door, asked him/her what he/she was doing and that Resident #1 said he/she was trying to get out. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA #1 said Resident #1 had been pacing back and forth up and down the hallway, kept trying to exit out the alarmed, locked exit door at the end of the hallway and that Resident #1 somehow broke the alarm mechanism of the door, so that the alarm kept sounding. CNA #1 said it was difficult to monitor Resident #1 that day, and that she had redirected Resident #1 multiple times (between 7:00 A.M. and 11:20 A.M.) away from the exit door at the end of the hall. CNA #1 said that around 11:20 A.M., she told Nurse #1 that she was going on a short break and when she left the unit, she saw Resident #1 talking with Nurse #1 at the medication cart. CNA #1 said she returned from break at approximately 11:40 A.M., started to help pass lunch trays, that as she walked by Resident #1's room she noticed that he/she was not there, and she did not see him/her anywhere in the hallway, so she went into Resident #1's room to look for him/her and he/she was not in there. CNA #1 said that she immediately went and told Nurse #1 that she thought Resident #1 was missing. CNA #1 said she did not know how Resident #1 exited the unit. Review of Resident #1's Nurse Progress Note (written by Nurse #1), dated 11/02/24, indicated that Resident #1 appeared unsettled, was wandering from room to room and he/she was asking to have someone book him/her a ride. The Note indicated that Resident #1 had been exit seeking through one of the locked, alarmed exit doors at the end of the hallway and at one point he/she broke the alarm on the door. During a telephone interview on 11/14/24 at 1:59 P.M., Nurse #1 said on 11/02/24 from 7:00 A.M. to 3:00 P.M., he was Resident #1's nurse. Nurse #1 said Resident #1 had been pacing back and forth, hanging out at the medication cart with him and repeatedly saying he/she wanted a ride home. Nurse #1 said that by approximately 9:00 A.M., Resident #1 had broken the locked, alarmed exit door at the end of the hallway from repeatedly trying to open the door, so the alarm would not stop sounding, and was unable to be shut off for a few hours. Nurse #1 said he notified Nurse #2 (who was working on another unit in the facility) and Nurse #3 (who was working on the other side of Unit 2) that the exit door was broken and asked them what to do. Nurse #1 said that both Nurse #2 and Nurse #3 said that they were too busy and did not have time to help him. Nurse # 1 said when CNA #1 informed him that she was going to take a break, he directed Resident #1 to go into the day room to join an activity that was happening and said he saw Resident #1 going toward that direction. Nurse #1 said that at approximately 11:45 A.M., CNA #1 notified him that Resident #1 was missing. Nurse #1 said they began to search for him/her immediately. Nurse #1 said when he went to check outside in the designated smoking area (which was fenced in), he noticed that there were two gates and said the gate leading to the back parking lot was not secured and was wide open. Nurse #1 said it was only after the fact of Resident #1's elopement, that he was made aware that Resident #1 had tried to exit the building the day before. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nurse #1 said that he was not aware that there was a Weekend Supervisor in the building or that the Director of Maintenance had been in the building as well that day. Nurse #1 said the Director of Maintenance only came up to Unit 2 to try and fix the alarm on door that would not stop sounding, after Resident #1 had already been noted as missing. During an interview on 11/14/24 at 10:13 A.M., the Director of Maintenance said that he had been in the Facility on 11/02/24 and was unaware that the alarm had been broken on the exit door at the end of the hallway on Resident #1's unit. The Director said when he was made aware that the exit door had been broken, Resident #1 was already identified as missing. The Director said that when he went to check the exit door on Resident #1's unit, the alarm was still sounding, and that a staff member had to enter the access keycode number to let him onto the unit. During a telephone interview on 11/22/24 at 10:15 A.M., the Weekend Supervisor said that on 11/02/24, she went into work that day at 7:00 A.M. and said she rounded on the second floor (Resident #1's unit), said hello to Nurse #3, two of the three CNA's and then headed to the third floor where she was assigned to be the second nurse for the 7:00 A.M. to 3:00 P.M. shift. The Supervisor said that she was unaware that the second floor had a challenging resident (Resident #1) that had been exit seeking and said she never heard any alarms going off. The Supervisor said right around 12:00 P.M., she was exiting a resident's room, saw staff running around, that she was then made aware Resident #1 was missing and that she announced a Missing Person Emergency Code, called to informed the police, Director of Nurses and the Administrator. During an interview on 11/14/24 at 11:43 A.M., Nurse #2 said that on 11/02/24 around lunch time, a nurse from the second floor came up to the third floor looking for Resident #1. Nurse #2 said that he began helping with the search and that the Missing Person Emergency Code (announced over the Facility intercom with location and directions) announcement was made. During an interview on 11/14/24 at 2:33 P.M., Resident #1 told the surveyor that he/she had taken a trip a few days ago, went for a long walk, and somehow ended up back at the Facility. Resident #1 said that he/she walked all the way to Woburn, that his/her feet hurt, and he/she had blisters and sores on them because it had been such a long walk (3.6 miles). Resident #1 said someone had picked him/her up and brought him/her to a hospital to be evaluated. Resident #1 said he/she could not remember how he/she got out of the building. Review of the website Weather.com, for weather conditions on 11/02/24 into 11/03/24 for Arlington and Woburn, indicated the during the day on 11/02/24 the daytime temperature on days in both cities and was between 50-55 degrees Fahrenheit (F), however the overnight temperature in both cities on 11/03/24 was between 30-31 degrees (F). Although staff members recall seeing Resident #1 dressed in street clothes at the start of the day shift on 11/02/24, there is no evidence to support he/she had on a winter or heavy warm coat to protect him/her from the cold overnight/early morning temperatures on 11/03/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's Hospital Discharge Summary, dated 11/05/24, indicated he/she had been transferred and admitted to the Hospital after being found by police at a convenience store. The Summary indicated Resident #1 was diagnosed with leukocytosis (increased number of white blood cells, that could be caused by an infection, inflammation, an injury, or immune system disorders), Acute Kidney Injury (AKI) from dehydration, and wounds to both feet and toes. During an interview on 11/14/24 at 2:50 P.M., the Director of Nurses (DON) said that despite all their search efforts, they were unable to locate Resident #1. The DON said that Resident #1 was found the next day by the police in a different town, more than three miles away in a grocery store. The DON said they were unable to determine exactly how Resident #1 got off the unit or how he/she exited the facility. 2) Review of the Facility Policy titled Smoking, undated, indicated that those residents who desire to smoke are allowed the privilege to do so outside, while supervised by a designated staff member. The Policy also indicated that there were designated smoking times at scheduled predetermined intervals (at the discretion of the Facility); -9:00 A.M.,11:30 A.M., 1:00 P.M., 4:00 P.M., 6:00 P.M., and 11:30 P.M. During a tour of the facility on 11/15/24 at 7:55 A.M., the Surveyor conducted observations in the designated smoking area utilized by the residents and they were as follows: -The designated smoking area is in the back of the building and is located just outside of the day room on the second floor (Resident #1's unit). -The smoking area is fenced in by a chain link fence (about 3 feet high) and there were two (2) gates, one on each end of the smoking area. -One of the gates, if you exit through it, leads to the front side of the building. -The other gate, if you exit through it, leads to the side of the building. - However, both gates allow anyone going out through them to access the facility parking lot, which take you to the front of the building, which is off a main road, and allows anyone to walk away from facility grounds. -The gate leading to the back of the building was unsecured and was wide open. -There was one resident out in the patio area smoking a cigarette, unsupervised by staff. -The were no staff members present in the day room or out in the smoking area. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/14/24 at 12:27 P.M., the Activity Assistant said on 11/02/24 (the day Resident #1 went missing) sometime before lunch, while she was doing an activity in the day room, two residents entered the day room and asked her if they could outside to smoke (the door used by staff/residents to go in/out to the designated smoking area is located in the day room). The Activity Assistant said she let the two residents out into the designated smoking area by entering a code into the keypad that releases the door. The Activity Assistant said she did not go outside to the smoking area to supervise the two residents, that she stayed in the day room and continued doing an activity with the other residents. The Activity Assistant said from inside the day room, she watched the residents smoking outside and monitored the residents participating in the activity in the day room, at the same time. The Activity Assistant said that is what she usually does when there is an activity running at the same time there is a scheduled smoking break going on. However, this was not consistent with the facility's Smoking Policy, which indicated that residents could go outside to smoke while under the supervision of a designated staff member. During an observation on 11/15/24 at 7:55 A.M., the Surveyor also noted the following in the day room on Unit 2, which is where the door with access to the designated smoking area is located: - Inside the day room, there was a keypad mounted on the wall to the left of the door that exits out into the smoking area. The keypad requires an access code be entered into it, in order for the locking mechanism to release and open the door. -On the wall on the outside the door, (in the smoking area) there is another keypad mounted on the wall next to door, which also requires an access code to be entered into it, in order to be able to open the door and re-enter the building. During an interview on 11/15/24 at 8:00 A.M., Resident #4 said that the designated smoking area is located off the main dining room/day room on the second floor. Resident #4 said he/she smokes, can smoke alone, and that he/she does not need anyone to be with him/her while smoking. The Surveyor asked Resident #4 if he/she had the code number to the keypad to open the door to exit and enter, he/she said yes and he/she provided the keypad code numbers to the Surveyor. During an interview on 11/15/24 at 8:25 A.M., Resident #5 said that he/she was a smoker and was independent with smoking. Resident #5 said a staff member watches them from inside of the building. Resident #5 said that he/she did not know the codes to get out or back in from the designated smoking area. During an observation on 11/15/24 at 8:31 A.M., the Surveyor saw Resident #6 out in the designated smoking area smoking a cigarette, however there was no staff member present in the smoking area providing supervision. At 8:34 A.M. the Surveyor observed Resident #6 enter numbers into the keypad from the outside, the lock on the disengaged, and he/she came back into the building. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation on 11/15/24 at 8:37 A.M., the Surveyor observed Resident #5, (who previously stated that he/she did not know the codes to the doors keypads) enter the day room on the second floor, he/she went to the keypad, entered numbers into it and was able to exit the day room out to the designated smoking area independently. There were no staff members present in the day room to let the Resident #5 out or back in from the smoking area. There were no staff members present out in the smoking area to provide supervision for Resident #5 when he/she went outside to smoke. Resident #5 was outside alone for about 20 minutes unsupervised by staff while smoking, until 8:57 A.M., when the Activity Director arrived. During an interview on 11/15/24 at 8:59 A.M., the Unit Manager said that she was not aware that any residents had the access codes to exit the building to go out to the smoking area, and said there should always be a staff member outside with the smokers until the smoking break is over. During an interview on 11/15/24 at 2:00 P.M., the Director of Nurse (DON) said that he was unaware that some of the residents knew the access codes to the keypad to exit out to the designated smoking area. The DON said that it is the Facility's expectation that none of the residents are provided with the keypad codes to any exit doors. The DON said that the gates outside in the designated smoking area are supposed to be kept locked at all times. The DON said residents are not allowed to be in the designated smoking area unless they are supervised by a Facility employee, and that the staff member must be outside while the residents are out there. The DON said it was not acceptable for the designated staff member to stay inside in the day room to monitor the residents who are outside, as that would leave the residents outside smoking unsupervised.