STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305055	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oceanside Skilled Nursing and Rehabilitation	22 Tuck Road Hampton, NH 03842

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. 26364 Based on interview and record review, it was determined that the facility failed to ensure residents received adequate supervision when a door alarm sounded resulting in a resident elopement for 1 of 2 residents reviewed for elopement (Resident Identifier #1). Findings include: Interview on 8/23/24 at approximately 8:30 a.m. with Staff C (Administrator) revealed that on 7/28/24, Resident #1 left the premises through the front door with a wanderguard on. The door alarm sounded and was deactivated by Staff B (Recreational Assistant) at approximately 5:15 p.m. Staff were looking for Resident #1 to go out on a smoking break around 6:30 and Staff D (Licensed Nursing Assistant) reported that he/she had seen the resident at a nearby gas station. Interview on 8/23/24 at approximately 10:30 a.m. with Staff A (Nurse Practice Educator) revealed he/she was on-call the evening of 7/28/24 and learned of the elopement at approximately 6:30 p.m. The facility discovered that Resident #1 took a taxi from the gas station to a homeless shelter approximately an hour away. The police department and hospitals near the shelter were notified. Resident #1 went to a fire station instead of the shelter with a complaint of abdominal pain and was taken to a nearby hospital. The resident has returned to the facility. Interview on 8/23/24 at approximately 11:05 a.m. with Staff B revealed he/she heard the front door alarm going off when he/she entered the lobby from a unit. Staff B did not know how long the alarm had been sounding. Staff B checked the parking lot for residents and did not see any residents in the vicinity. Staff B re-entered the facility lobby, turned the door alarm off, did not notify a nurse the alarm had sounded and Staff B left for the day. Review on 8/23/24 of the facility's in-service staff education sheet revealed all staff had been educated on the facility's elopement policy and what to do when a door alarm is going off was reviewed and completed between 7/29/24 through 7/30/24. Review on 8/23/24 of the facility's mock elopement drills revealed the drills had been completed weekly since 8/2/24. (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: 305055	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Oceanside Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 22 Tuck Road Hampton, NH 03842	

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	Review on 8/23/24 of the facility's Root Cause Analysis (RCA) completed on 7/29/24 revealed the system failures and assigned various managers to oversee different areas for improvement in keeping the staff aware of the elopement process. This RCA was submitted to the Quality Assurance Committee for review on 7/29/24. This RCA included the following areas: immediate actions, (elopement risks, book) what changes were made to the system, (increase sensitivity, what happens when alarm goes off, re-education) and what needed to be maintained (assess function of secure care system monthly, and audits). Review on 8/23/24 of the facility's policy titled: Elopement of Patient, last revised 10/24/22, revealed: Elopement is defined as any situation in which a patient leaves the premises or a safe area without the facility's knowledge and supervision, if necessary . 2. Witnessed Attempted or Actual Elopement: 2.1 Staff witnessing a confused patient or an identified elopement risk patient attempting to leave the Unit and/or Center accompanied (sic) will intervene as appropriate to redirect the patient to a safe area and prevent elopement. 3. Unwitnessed Elopement 3.1 Notify the supervisor that the patient is missing. 3.2 Supervisor will alert all staff of missing patient with an announcement to activate missing patient protocol .