

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335172	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER Comprehensive Rehab & Nursing Ctr at Williamsville		STREET ADDRESS, CITY, STATE, ZIP CODE 147 Reist Street Williamsville, NY 14221	

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 - Some</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** 43785</p> <p>Based on observations, interviews, and record reviews conducted during an Abbreviated Partial Extended survey (Complaint #NY00345600), the facility failed to provide an environment free of accident hazards and adequate supervision to prevent elopement for seven (Resident #1, #2, #3, #4, #5, #6, and #7) of seven residents reviewed. Specifically, on 6/18/2024 at 4:30 AM, staff returned Resident #1 to the facility after they were found outside. The facility failed to initiate safety interventions after Resident #1 eloped to prevent recurrence. Subsequently, at 6:30 AM facility staff were unable to locate Resident #1 and local authorities were called. Resident #1 was returned to the facility at 4:00 PM by their Health Care Proxy. Additionally, windows in resident rooms of those identified at risk for elopement did not have adequate safety devices to prevent the window from being fully opened. This involved Resident's #1, #2, #3, #4, #5, #6, and #7. This resulted in the likelihood for harm that is immediate jeopardy and substandard quality of care to Resident #1's health and safety and had the potential to affect seven residents in the facility identified as being an elopement risk.</p> <p>The findings include, but are not limited to:</p> <p>The policy and procedure titled Elopement/Missing Resident dated 2/2016 documented any resident identified as a risk for elopement will be reassessed monthly. Plant Operations will provide maintenance and monitor preventive maintenance schedules for elopement prevention devices. Exit seeking behavior may include but not be limited to history of elopement, opening doors to the outside, making statements referencing leaving the facility, seeking to find someone/something outside of facility, noncompliance with facility protocols. The policy and procedure documented upon the return of a missing resident; the resident would be placed on every 15 minutes visual checks for the first 24 hours following the incident. Documentation would include modification to the comprehensive and closet care plan.</p> <p>1. Resident #1 had diagnoses which included dementia, Alzheimer's disease, and alcohol abuse. The Minimum Data Set (a resident assessment tool) dated 5/24/2024 documented Resident #1 was cognitively intact, usually understands and was usually understood by others.</p> <p>The comprehensive care plan dated 3/21/2024 documented Resident #1 was at risk for elopement related to a history of elopement. Interventions included to monitor the wander alert device every shift. Resident #1 had impaired cognitive function/dementia and impaired thought processes related to Alzheimer's. Interventions included to communicate with the resident and caregivers regarding resident's capabilities and needs.</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
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The Wandering/ Elopement Risk Assessments dated 11/16/2023, 2/16/2024, 5/16/2024 and 6/18/2024 documented Resident #1 was at low risk for wandering and elopement.</p> <p>The Kardex (guide used by staff to provide care) dated 6/21/2024 documented Resident #1 was independent with all activities of daily living and to monitor the wander alert device on their right ankle every shift. The facility was unable to provide a Kardex that was in effect on the day of the resident's elopement.</p> <p>Review of the Nursing Progress Notes revealed the following:</p> <p>-6/18/2024 at 4:18 AM, Nursing Supervisor Registered Nurse #1 documented that Resident #1 was found outside of the building by Certified Nurse Aide #1. Nursing Supervisor Registered Nurse #1 documented they went to assist Resident #1 back into the facility. The resident was very angry and verbally abusive as they were brought back inside the building. Nursing Supervisor Registered Nurse #1 documented they encouraged unit staff to keep an eye on the resident and Licensed Practical Nurse #1 stated they would put Resident #1 on 15-minute checks. At 6:50 AM, Nursing Supervisor Registered Nurse #1 documented Licensed Practical Nurse #1 notified them Resident #1 was not in their room. A total building check and a vehicle search was started. The Director of Nursing, the Assistant Director of Nursing and emergency services were notified.</p> <p>-6/18/2024 at 7:22 AM, Licensed Practical Nurse #1 documented at 4:25 AM they were informed that Resident #1 was found outside of the building and was escorted back into the building to their room. The note documented Resident #1 did not want to return to the facility. Education was provided, and Resident #1 agreed to stay. At 6:40 AM Licensed Practical Nurse #1 went to Resident #1's room to administer medications and Resident #1 was not there. The resident was unable to be located within the building and the surrounding grounds.</p> <p>-6/18/2024 at 4:50 PM, the Director of Nursing documented that Resident #1 returned to the facility via their Health Care Proxy's car. The note documented Resident #1 had stated they were jimmying their window for a few days, released the window stopper and climbed out of the window.</p> <p>There was no documented evidence that 15-minute checks were completed.</p> <p>According to the National Oceanic and Atmospheric Administration weather service, the local weather on 6/18/2024 from 6:00 AM-4:00 PM was between 73 degrees Fahrenheit and 92 degrees Fahrenheit, with a heat index between 79 degrees Fahrenheit and 101 degrees Fahrenheit. Heat advisory and poor air qualities were in effect.</p> <p>During an interview on 6/20/2024 at 8:34 AM, Resident #1 stated they no longer wanted to stay at the facility. They stated at 4:00 AM they climbed out of their bedroom window but not long after they were brought back inside by staff. Resident #1 stated when no one was watching, they climbed out of their window a second time. The resident stated they waited on a bench until it was day light, then took a bus to the area of a local hospital. Resident #1 stated they had walked around until they got into a stranger's car and was dropped off at their Health Care Proxy's house. Resident #1 stated it was hot, and they needed to rest every 15-20 minutes. The resident stated they were sore from all the walking and had fallen but did not hurt themselves.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During a telephone interview on 6/20/2024 at 10:53 AM, Certified Nurse Aide #1 stated they were on their break on 6/18/2024 around 4:30 AM when they saw Resident #1 walking up the hill on the parking lot side of the building with a pillowcase filled with their own belongings. Certified Nurse Aide #1 stated along with Nursing Supervisor Registered Nurse #1 they brought Resident #1 back into the building. Certified Nurse Aide #1 stated they went back to their own unit to work and did not see Resident #1 after that. Certified Nurse Aide #1 stated Resident #1 had a previous history of exit seeking behaviors when they were on Unit 1 (Rehab Unit).</p> <p>During a telephone interview on 6/20/2024 at 11:32 AM, Certified Nurse Aide #2 stated they were responsible for Resident #1 from 10:00 PM to 6:00 AM on 6/17/2024 - 6/18/2024. Certified Nurse Aide #2 stated they were never notified Resident #1 had eloped at 4:30 AM until the Director of Nursing telephoned them just a bit ago on 6/20/2024. Certified Nurse Aide #2 stated the last time they saw Resident #1 was on 6/17/2024 about 10:30 PM. They stated they were never given instructions that Resident #1 was to be on 15-minute visual checks.</p> <p>During a telephone interview on 6/20/2024 at 11:34 AM, Licensed Practical Nurse #1 stated on 6/18/2024 at 4:30 AM they were alerted by a staff member that Resident #1 was outside and was escorted back into the building. Licensed Practical Nurse #1 stated about 20 minutes after Resident #1 was returned to their room they spoke with Nursing Supervisor Registered Nurse #1 about starting 15-minute checks. Licensed Practical Nurse #1 stated they did not instruct staff working on the unit to do 15-minute checks and they did not do 15-minute checks. Licensed Practical Nurse #1 stated about 6:25 AM they went to Resident #1's room to administer medications and the resident was not in their room. Licensed Practical Nurse #1 stated Resident #1 had a history of exit seeking behaviors.</p> <p>During a telephone interview on 6/20/2024 at 12:07 PM, Nursing Supervisor Registered Nurse #1 stated on 6/18/2024 at 4:30 AM Resident #1 was found outside and was brought back into the facility. Nursing Supervisor Registered Nurse #1 stated they discussed the elopement with Licensed Practical Nurse #1. Licensed Practical Nurse #1 stated they would put Resident #1 on 15-minute checks. Nursing Supervisor Registered Nurse #1 stated they did not notify Certified Nurse Aide #2 (assigned aide) that Resident #1 had eloped. Nursing Supervisor Registered Nurse #1 stated they left the unit and did not return until around 6:45 AM when they were notified Resident #1 was not in their room. Nursing Supervisor Registered Nurse #1 stated they did not ensure the 15-minute checks were completed. Nursing Supervisor Registered Nurse #1 stated Resident #1 had a history of exit seeking behavior and verbalized desires to leave the facility.</p> <p>During a telephone interview on 6/22/2024 at 12:29 PM, Certified Nurse Aide #3 stated they were responsible for Resident #1 on 6/18/2024 from 6:00 AM - 2:00 PM. They stated when they started their shift, they were not instructed to complete 15-minute checks on Resident #1 and a search for the resident was already in progress.</p> <p>During a telephone interview on 6/20/2024 at 3:49 PM, Resident #1's Health Care Proxy stated they had received a telephone call from a concerned citizen that they had found Resident #1 walking around the area by a local hospital, and that they had the resident in their vehicle. The concerned citizen drove Resident #1 to the Health Care Proxy's house. The Health Care Proxy stated they eventually returned Resident #1 back to the facility which was about a 25-minute drive away.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 6/20/2024 at 10:00 AM, the Maintenance Director stated prior to Resident #1's elopements on 6/18/2024, Resident #1's windows were secured the same as a typical resident room window. The room next door to Resident #1's room was used as an example. Both windows were equipped with a snap-on plastic window stop in one of two vertical tracks. They could be removed by hand without the use of a tool. With the window stops removed, the bottom window sash could be lifted to open an area that was 27 and one-half inches wide by 22 inches high by turning the center sash latch. Regardless of the presence of the plastic window stop, the top window sash could be lowered to an open area that was similar in dimension by clasping the top sash latch. A window screen was present in the bottom half of the window and could be lifted without any additional effort. The plastic window stop measured 15 inches long by one and a half inches wide and snapped into the vertical window track. The Maintenance Director stated clinical staff decided the elopement risk level for each resident and they would have to let maintenance staff know if the windows in those rooms needed more security. They stated they were not informed about Resident #1's elopement risk status until after the elopements on 6/18/2024.</p> <p>Observations from the exterior of the building on 6/20/2024 at 9:45 AM and 4:00 PM revealed Resident #1's window was located within a fully fenced-in courtyard with a community gated entrance. The fence was approximately five feet tall. The bottom of the window had an exterior sill and the vertical distance from the sill to the ground below was 33 inches.</p> <p>Resident #2 had diagnoses which included dementia, depression, and anxiety. The Minimum Data Set, dated dated dated [DATE] documented Resident #2 had severe cognitive impairment.</p> <p>The comprehensive care plan dated 6/20/2024 documented Resident #2 was at risk for elopement related to a history of wandering.</p> <p>An interview and observation of Resident #2's room conducted on 6/20/2024 at 12:15 PM revealed the room contained two windows that were double-hung style. The window on the right had a plastic window stop in one of two vertical tracks that could be removed by hand without the use of a tool. With the window stop removed, the bottom window sash could be lifted to an area that was 34 inches wide by 22 inches high. The window on the left had a plastic window stop in one of two vertical tracks that was screwed in, and when the bottom sash was lifted, it opened six inches high. Regardless of the presence of the plastic window stop, if the top sash latch was clasped, the top window sash of both windows could be lowered to open an area that was 34 inches wide by 21 inches high by clasping the top sash latch. A window screen was present in the bottom half of the window and could be lifted without any additional effort. The Maintenance Director stated they were unaware of which residents were identified as an elopement risk. They stated if they were made aware that a resident was an elopement risk, they would add extra security measures to that resident's window, such as screwing in the stoppers, or adding a screw to the bottom or top of the window.</p> <p>Resident #3 had diagnoses including dementia, hypertension, and atherosclerotic heart disease (hardening of the arteries). The Minimum Data Set, dated dated dated [DATE] documented the resident had severe cognitive impairment.</p> <p>The comprehensive care plan dated 1/29/2024 documented Resident #3 was at risk for elopement related to attempts to leave the facility unattended and had impaired safety awareness.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Observation of Resident #3's room on 6/20/2024 at 12:55 PM revealed the room contained two windows that were a double-hung style. The window on the left had a plastic window stop in one of two vertical tracks. The window stop could be removed out of the track, by hand without the use of a tool. With the window stop removed, the bottom window could be lifted to an area that was 28 inches wide by 21 inches high. The window on the right had a plastic window stop in one of two vertical tracks that was screwed in, and when the bottom sash was lifted, it opened six inches high. Regardless of the presence of the plastic window stop, if the top sash latch was clasped, the top window sash of both windows could be lowered to open an area that was 28 inches wide by 22 inches high. A window screen that was present in the bottom half of the window and could be lifted without any additional effort.</p> <p>During an interview on 6/20/2024 at 1:50 PM, the Maintenance Director stated some plastic window stops could be removed from the window track with fingers, but some were harder to remove, and they needed to use a tool to pry them out.</p> <p>During an interview and observation on 6/20/2024 at 5:50 PM, Licensed Practical Nurse #3 Unit Manager stated windows should only open six inches. They stated if a resident was an elopement risk, the window stoppers should be drilled in. Licensed Practical Nurse #3 Unit Manager stated if a window was able to be opened from the top down even with the window stopper in place was a safety risk. They stated if nursing staff saw a window stop on the window, it was considered alright, but if nursing staff noticed a window stop was missing, they would notify the maintenance staff.</p> <p>During an interview and observation on 6/20/2024 at 6:25 PM, the Director of Nursing stated all resident room windows needed stoppers and should only open six inches high. After Resident #1 eloped from the facility, all resident windows were checked by staff for the presence of window stoppers. At this time, the snap-on plastic window stop from the resident room next to Resident #1's room was shown to the Director of Nursing. The Director of Nursing stated they did not know the window stops could pop out that easily, and stated they needed to be secured. The Director of Nursing stated they were unaware the top windowpane opened from the top down, and something was needed to prevent the windows from opening.</p> <p>During an interview on 6/21/2024 at 9:23 AM, the Administrator stated in response to the elopement a window audit was completed on 6/18/2024 by Licensed Practical Nurse #3 Unit Manager, Licensed Practical Nurse #4 Unit Manager, and the Director of Activities. They checked to see if the windows opened greater than six inches from the bottom up. The Administrator stated the words stopper in place or a checkmark on the 6/18/2024 audit meant that plastic window stops were in place. Window stops were not checked for secureness or looseness during the audit.</p> <p>10NYCRR 415.12(h)(1)(2)</p>