

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/05/2024
NAME OF PROVIDER OR SUPPLIER Troy Victorian Rehabilitation & Nursing Care Cntr		STREET ADDRESS, CITY, STATE, ZIP CODE 100 New Turnpike Road Troy, NY 12182	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>33538</p> <p>Based on observation, interview, and record review conducted during an Abbreviated Survey (Case #NY00345181), the facility did not ensure the resident's right to be free from neglect for 1 (Resident #1) of 1 resident reviewed for abuse and neglect. Specifically, the facility did not ensure supervision and oversight was provided following an attempted elopement on 6/11/2024. This resulted in an actual elopement on 6/14/2024.</p> <p>This is evidenced by:</p> <p>The Policy and Procedure titled, Elopement, effective 4/01/2024, documented it was the responsibility of all personnel to report any resident attempting to leave the premises to the Unit Manager and/or Charge Nurse immediately.</p> <p>The Policy and Procedure titled, Wander Guard, effective 4/1/2024, documented any resident with a new elopement attempt was to have an electronic monitoring device applied and care plan updates immediately. Should an elopement attempt/episode occur, the contributing factors, as well as the interventions tried, would be documented on the nurses' notes.</p> <p>Resident #1 was admitted to the facility with diagnoses of cognitive communication deficit (condition that may include memory problems, learning disorders, attention problems, or problems with processes that help people connect their past experiences with their present action), anxiety disorder, and bipolar disorder (a mental illness that causes unusual shifts in a person's mood). The Minimum Data Set (an assessment tool) dated 5/12/2024, documented the resident could be understood, could understand others, and had intact cognition for decisions of daily living.</p> <p>An Incident Report dated 6/14/2024 documented a staff member (Occupational Therapist #2) who was coming into work saw Resident #1 enter the parking lot near the front entrance. The resident was brought into the building and an electronic monitoring device was applied to left ankle.</p> <p>The Comprehensive Care Plan titled at risk for elopement related to impaired safety awareness was initiated on 6/14/2024. The interventions included an electronic monitoring device.</p> <p>A Nursing Progress Note dated 6/11/2024, documented resident went out front door today with 2 packed bags. Remained in sight of staff at all times. Easily redirected inside, was calm and agreed to stay inside.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Progress Note dated 6/14/2024, documented Resident found in upper parking lot at approximately 7:19 AM.</p> <p>A Nursing Progress Note dated 6/14/2024, documented an electronic monitoring device was placed on left ankle for safety.</p> <p>The Medication and Treatment Administration Records for June 2024 did not include documentation of electronic monitoring device.</p> <p>During an observation and interview on 6/17/2024 at 10:35 AM, Resident # 1 stated they could go outside with staff but not alone. At the time of the interview, there was no electronic monitoring device observed on the resident's left ankle.</p> <p>During an observation and interview on 6/17/2024 at 11:50 AM Licensed Practical Nurse #1 stated they were told by the unit manager that the resident had an electronic monitoring device but had not checked for placement yet. Licensed Practical Nurse #1 then proceeded to where Resident #1 was located. When asked by Licensed Practical Nurse #1 if Resident #1 had an electronic monitoring device on, Resident #1 stated they took it off. When asked who took it off, the resident smiled and stated, I cut it off, it was too tight. Resident #1 stated they were not sure when they took it off. Licensed Practical Nurse #1 checked the Resident's ankles and looked around the room for the electronic monitoring device; device was not found.</p> <p>During an interview on 6/17/2024 at 3:15 PM, Social Worker #3 stated they were at the copy machine on 6/11/2024 between 7:30 AM and 8:00 AM and watched the resident walk outside. They followed the resident and brought them up to their room. Social Worker #3 did not report it to anyone on the unit at that time. Social Worker #3 stated that, within one hour, they brought the incident up at morning meeting and Licensed Practical Nurse #2 was present. Social Worker #3 stated they should have reported it to the Director of Nursing and the Administrator.</p> <p>During an interview on 6/17/2024 at 11:30 AM, Occupational Therapist #2 stated they were coming into work on 6/14/2024 and saw Resident #1 in the parking lot approximately 30-40 feet away from the front door. They brought her back in and told the nurse on the unit that the resident was outside.</p> <p>During an interview on 6/17/2024 at 1:55 PM, Registered Nurse #1 stated they were not made aware of the elopement attempt on 6/11/2024, and that an electronic monitoring device should have been placed, with 15-minute checks implemented.</p> <p>During an interview on 6/17/2024 at 3:45 PM, Licensed Practical Nurse #2 stated they were not at the morning meeting on 6/11/2024 because they were doing rounds with the doctor, and they were not told about the elopement attempt. They further stated if they had been told, they would have started an Incident report and placed an electronic monitoring device on the resident immediately.</p> <p>During an interview on 6/17/2024 at 12:20 PM, Assistant Director of Nursing #1 stated they were told Resident #1 was found in parking lot by therapy. They placed an electronic monitoring device on the resident. Stated the unit manager should have entered an order that would result in the check function and placement being on the Treatment Administration Record, then we would have known the resident had removed the electronic monitoring device.</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 New York Codes, Rules and Regulations 415.4(b)(1)(i)

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>33538</p> <p>Based on record review and interviews during an abbreviated survey (Case # NY00345181), the facility did not ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 resident (Resident #1) of 1 resident reviewed for abuse, neglect, and mistreatment. Specifically, Resident #1 was found by staff in the parking lot approximately 40 feet from the front entrance to the facility. The incident was not reported to the New York State Department of Health.</p> <p>This is evidenced by:</p> <p>The facility's policy and procedure titled Abuse, Neglect, and Mistreatment - Reporting, documented if reasonable cause to believe that abuse has occurred exists (defined as meaning that upon a review of the circumstances, there is sufficient evidence for a prudent person to believe that abuse, neglect, or mistreatment has occurred), report to the New York State Department of Health via the Nursing Home Hotline.</p> <p>Resident #1 was admitted to the facility with diagnoses of cognitive communication deficit (condition that may include memory problems, learning disorders, attention problems, or problems with processes that help people connect their past experiences with their present action), anxiety disorder, and bipolar disorder (a mental illness that causes unusual shifts in a person's mood). The Minimum Data Set (an assessment tool) dated 5/12/2024, documented the resident could be understood, could understand others, and had intact cognition for decisions of daily living.</p> <p>An Incident Report dated 6/14/2024 documented a staff member (Occupational Therapist #2) who was coming into work saw Resident #1 enter the parking lot near the front entrance. The resident was brought into the building and an electronic monitoring device was applied to left ankle.</p> <p>During an interview on 6/17/2024 at 11:30 AM, Occupational Therapist #2 stated they came into work on 6/14/2024 and saw Resident #1 in the parking lot, approximately 30-40 feet away from the front door. They brought them back in and told the nurse on the unit that the resident had been found outside.</p> <p>During an interview on 6/17/2024 at 12:00 PM, Administrator #1 stated a resident elopement was reportable, however it was not an elopement because the staff saw the resident exit the building.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/17/2024 at 12:20 AM, Assistant Director of Nursing #1 stated they were told Resident #1 was found in parking lot by therapy. They placed a Wander Guard on the resident and put her on the list at the front desk for elopement risk. Assistant Director of Nursing #1 stated they were aware this was a reportable incident and believed the Administrator was aware of the elopement and would report accordingly.</p> <p>Record review of the surveillance video dated 6/14/2024 showed Resident #1 walking away from the building at video timestamp of 06:20:16 (AM). At 06:20:32 (AM) the resident stopped walking when it appears the staff recognized them from across the parking lot. At 06:20:50 (AM), the staff took Resident #1 by the hand and escorted them toward the front entrance. An interview with Administrator #1 confirmed the timestamp was incorrect and should have read 07:20 due to clock not changed for daylight savings.</p> <p>During an interview on 6/18/2024 at 11:00 AM, Director of Nursing #1 stated they were on leave when the incident occurred, today was their first day back. They did watch the surveillance video and would have reported it as an elopement if they had been here. Director of Nursing #1 and surveyor walked outside together and were able to determine from the markings on the pavement seen in the video, that the resident was approximately 40 feet away from the front door when the staff coming up from the lower parking lot (approximately 200 feet away from the entrance) saw the resident, approached, and escorted the resident toward the front entrance.</p> <p>10 New York Codes, Rules and Regulations 483.12(c)(1)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</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>33538</p> <p>Based on observations, interviews, and record reviews conducted during an Abbreviated survey (Case # NY00345181), the facility failed to provide an environment free of accident hazards and adequate supervision to prevent elopement for 1 (Resident #1) of 3 residents reviewed for elopement. Specifically, on 6/11/2024, Resident #1 was observed leaving the facility through the front entrance. The facility did not put any measures in place to prevent further elopements. Subsequently, on 6/14/2024, Resident #1 was observed in the parking lot by facility staff and was brought back into the facility. On 6/14/2024 an electronic monitoring device was placed on the resident; however, the facility did not implement a system to monitor the resident for elopement or for the placement of the electronic monitoring device. This resulted in no actual harm with the likelihood for more than minimal harm that was Immediate Jeopardy and Substandard Quality of Care for Resident #1.</p> <p>This is evidenced by:</p> <p>The Policy and Procedure titled, Elopement, effective 4/01/2024, documented it was the responsibility of all personnel to report any resident attempting to leave the premises to the Unit Manager and/or Charge Nurse immediately.</p> <p>The Policy and Procedure titled, Wander Guard, effective 4/01/2024, documented any resident with a new elopement attempt needed to have a Wander-Guard applied and care plan updated immediately. Should an elopement attempt/episode occur, the contributing factors, as well as the interventions tried, were to be documented on the nurses' notes.</p> <p>Resident #1 was admitted to the facility with diagnoses of cognitive communication deficit (condition that may include memory problems, learning disorders, attention problems, or problems with processes that help people connect their past experiences with their present action), anxiety disorder, and bipolar disorder (a mental illness that causes unusual shifts in a person's mood). The Minimum Data Set (an assessment tool) dated 5/12/2024, documented the resident could be understood, could understand others, and had intact cognition for decisions of daily living.</p> <p>An Elopement Risk Evaluation completed on 5/06/2024 documented the resident had no elopement risk.</p> <p>Review of the Progress Notes revealed the following:</p> <ul style="list-style-type: none"> - On 6/11/2024, Resident #1 went out front door today with 2 packed bags. Remained in sight of staff at all times. Easily redirected inside, was calm and agreed to stay inside. - On 6/14/2024, Resident #1 found in upper parking lot at approximately 7:19 AM. - On 6/14/2024, Resident #1 stated they can hear someone over the loudspeaker announcing they are going to jail and would ask various staff if the police were on their way. Reassurance was given but not received. Electronic monitoring device was placed on the left ankle for safety. <p>Elopement attempt on 6/11/2024:</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 - Few</p>	<p>During an interview on 6/17/2024 at 3:15 PM, Social Worker #3 stated they were at the copy machine on 6/11/2024 between 7:30 AM and 8:00 AM and watched the resident walk outside. They followed the resident and brought them up to their room. Social Worker #3 did not report it to anyone on the unit at that time. Social Worker #3 stated that, within one hour, they brought the incident up at morning meeting and Licensed Practical Nurse #2 was present. Social Worker #3 stated they should have reported it to the Director of Nursing and the Administrator.</p> <p>During an interview on 6/17/2024 at 1:55 PM, Registered Nurse #1 stated they were not made aware of the elopement attempt on 6/11/2024, and that an electronic monitoring device should have been placed, with 15-minute checks implemented.</p> <p>During an interview on 6/17/2024 at 3:45 PM, Licensed Practical Nurse #2 stated they were not at the morning meeting on 6/11/2024 because they were doing rounds with the doctor, and they were not told about the elopement attempt. They further stated if they had been told, they would have started an Incident report and placed an electronic monitoring device on the resident immediately.</p> <p>An Attendance Sign-in Sheet for a morning meeting dated 6/11/2024 at 9:00 AM and titled, Report, documented Social Worker #3, Rehabilitation Director #4, and the Assistant Director of Nursing were present. There was no documentation of Licensed Practical Nurse #2, Administrator, or Director of Nursing #1 being present for the meeting.</p> <p>Elopement on 6/14/2024:</p> <p>Record review of the surveillance video dated 6/14/2024 showed Resident #1 walking away from the building at video timestamp of 06:20:16 (AM). At 06:20:32 (AM) the resident stopped walking when it appears the staff recognized them from across the parking lot. At 06:20:50 (AM), the staff took Resident #1 by the hand and escorted them toward the front entrance. An interview with Administrator #1 confirmed the timestamp was incorrect and should have read 07:20 due to clock not changed for daylight savings.</p> <p>An Incident Report dated 6/14/2024 documented a staff member (Occupational Therapist #2) who was coming into work saw Resident #1 enter the parking lot near the front entrance. The resident was brought into the building and an electronic monitoring device was applied to left ankle.</p> <p>The Comprehensive Care Plan titled, at risk for elopement related to impaired safety awareness, was initiated on 6/14/2024. The interventions included: distract resident by offering pleasant diversions, provide structured activities, toileting, walking and reorientation strategies, and a wander alert.</p> <p>There was no Care Plan in place to address wandering and elopement risk prior to 6/14/2024.</p> <p>There was no Physician's Order for an electronic monitoring device.</p> <p>The Medication and Treatment Administration Records for June 2024 did not include documentation of an electronic monitoring device.</p> <p>Interviews:</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 - Few</p>	<p>During an interview on 6/17/2024 at 11:30 AM, Occupational Therapist #2 stated they came into work on 6/14/2024 and saw Resident #1 in the parking lot, approximately 30-40 feet away from the front door. They brought them back in and told the nurse on the unit that the resident had been found outside.</p> <p>During an interview on 6/17/2024 at 10:35 AM, Resident #1 stated they could go outside with staff but not alone. At the time of interview, an electronic monitoring device was not observed on the resident's left ankle.</p> <p>During an observation and interview on 6/17/2024 at 11:50 AM Licensed Practical Nurse #1 stated they were told by the unit manager that the resident had an electronic monitoring device but had not checked for placement yet. Licensed Practical Nurse #1 then proceeded to where Resident #1 was located. When asked by Licensed Practical Nurse #1 if Resident #1 had an electronic monitoring device on, Resident #1 stated they took it off. When asked who took it off, the resident smiled and stated, I cut it off, it was too tight. Resident #1 stated they were not sure when they took it off.</p> <p>During an interview on 6/17/2024 at 12:20 PM, Assistant Director of Nursing #1 stated they were told Resident #1 was found in the parking lot by therapy and placed an electronic monitoring device on the resident. Assistant Director of Nursing #1 stated the unit manager should have entered an order that would result in the check function and placement being on the Treatment Administration Record, then staff would have known the resident had removed the electronic monitoring device.</p> <p>During an interview on 6/18/2024 at 11:50 AM, Rehabilitation Director #4 stated they were at the morning meetings every day except the previous Thursday (6/13/2024). They did not recall discussing an elopement attempt prior to 6/14/2024.</p> <p>During an interview on 6/18/2024 at 11:00 AM, Director of Nursing #1 stated they were on leave when the incident occurred and it was their first day back and they watched the surveillance video. In an observation at this time, Director of Nursing #1 and surveyor walked outside together and were able to determine-from the markings on the pavement seen in the video-that the resident was approximately 40 feet away from the front door when the staff member appeared from the lower parking lot (approximately 200 feet away from the entrance), saw the resident, approached, and escorted the resident toward the front entrance.</p> <p>During an interview on 6/18/2024 at 10:35 AM, the facility Medical Director #1 stated they were made aware of the two elopements by Resident #1 but were not sure when. They stated the first elopement on 6/11/2024 was due to increased behaviors, delusions and hallucinations, and Medical Director #1 requested a psych consult. Medical Director #1 stated they did not order an electronic monitoring device because they thought Resident #1 had one already in place.</p> <p>During an interview on 6/18/2024 at 11:41 AM, Administrator #1 stated they did not recall if they were at morning meeting on 6/11/2024 and was not sure when they were made aware of the elopement attempt. Administrator #1 stated they determined it was not an elopement because the staff coming in saw the resident and brought them in safely.</p> <p>10 New York Codes, Rules, and Regulations 415.12(h)(1)(2)</p>		