Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/31/2024
Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335403 | A. Building<br>B. Wing | 09/13/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Wayne Health Care | 100 Sunset Drive<br>Newark, NY 14513 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>46526<br><br>Based on observations, interviews, and record review conducted during a Recertification Survey from 09/09/2024 to 09/13/2024, for one (Resident #154) of six residents reviewed for behaviors, the facility could not provide evidence that a thorough investigation was completed to ensure the resident's safety following a potential elopement incident. Specifically, Resident #154, who was identified as at risk for elopement and wore a wander guard bracelet (a wander management system which uses bracelets, sensors, and technology to alert staff when a resident tries to leave a safe area), was found outside without their wander guard bracelet on. Additionally, several days prior, Resident #154 was found without their wander guard bracelet on, stating it had fallen off. The facility could not provide evidence that thorough investigations were conducted to determine how the resident's wander guard came off in both instances. This is evidenced by the following:<br><br>The facility policy Event Accident Investigation Reporting Guidelines, dated reviewed April 2023, included that all events, accidents, unusual occurrences, and near-misses that occurred would be investigated in a timely manner and residents would receive prompt and adequate treatment. Every effort would be made to determine the cause of each accident and/or event and measures would be put into place to prevent reoccurrence.<br><br>Resident #154 has diagnoses that included stroke, seizures, and dementia. The Minimum Data Set Resident Assessment, dated 08/28/2024, revealed Resident #154 was cognitively intact.<br><br>Review of the Comprehensive Care Plan revealed Resident #154 was at risk for wandering. Interventions included monitoring the resident's attempts to leave the unit or facility, and a wander guard bracelet provided to alert the facility of wandering and/or elopement.<br><br>Review of Resident #154's Care Card (care plan used for Certified Nursing Assistants for daily care) included the resident was independent with ambulation, an elopement risk, and wore a wander guard bracelet on the ankle.<br><br>Review of Resident #154's electronic medical record revealed the following:<br><br>(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 |
|---|---|---|

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | a. In a nursing progress note, dated 08/25/2024, Licensed Practical Nurse #1 documented that the wander guard (system) was activated while maintenance was taking out the garbage. While checking all residents to ensure their wander guard bracelets were on (the residents), Resident #154 was not wearing their wander guard bracelet. Resident #154 said it had fallen off and a new wander guard was placed to Resident #154's left ankle.<br><br>b. In a nursing progress note, dated 08/31/2024 at 9:31 PM, Licensed Practical Nurse #2 documented that Resident #154 was found sitting outside in front of the building (no wander guard alert had been activated). The resident said they had taken their wander guard bracelet off with a pen. A new wander guard bracelet was placed.<br><br>The facility could not provide documented evidence that any investigation had been conducted to determine how Resident #154's wander guard bracelet had been removed on either instance.<br><br>During an interview on 09/09/2024 at 10:17 AM, Resident #154 stated that they had recently removed their bracelet (wander guard) because they wanted to go outside.<br><br>During an observation and interview on 09/12/2024 at 4:09 PM, Resident #154 was wearing a wander guard bracelet. When asked how they had previously removed their wander guard bracelet, Resident #154 said they took a pair of scissors from behind the nurses' desk and cut it off.<br><br>On 09/12/2024, the facility identified that a second resident had removed their wander guard twice with a pair of scissors found in their room. The incident remained under investigation by the facility.<br><br>During an interview on 09/13/2024 at 10:24 AM, Registered Nurse Clinical Leader #3 said wander guards may be applied to residents who are identified to be at high risk for elopement, if they have tried to leave the facility, or if they have made statements about leaving. Registered Nurse Clinical Leader #3 stated the nurses check every shift that the wander guard is on the resident and document it in the resident's electronic medical record. If a resident was found to not have their wander guard on, staff should try to figure out where it was and put on a new one if not found. Registered Nurse Clinical Leader #3 said finding a resident without their wander guard on should prompt an investigation to determine how it got off.<br><br>During an interview on 09/13/2024 at 10:44 AM, Registered Nurse Manager #2 said if a resident were found not wearing their wander guard bracelet, and they were still on the unit, they would probably not initiate an incident report, but they would ask staff how the resident got it off. Registered Nurse Manager #2 stated residents should not be able to get the wander guard bracelet off. Registered Nurse Manager #2 said an investigation was not conducted to determine how the resident's wander guard bracelet came off when discovered on 08/25/2024 or 08/31/2024 because the resident said they took it off with a pen. Registered Nurse Manager #2 said the 08/31/2024 event was an incident that required increased monitoring and interventions.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 09/13/2024 at 11:21 AM, the Director of Nursing said if a resident was found without their wander guard bracelet on, staff should determine how it came off and reapply the wander guard if appropriate. The Director of Nursing stated there are no instances in which a resident's wander guard should be off without staff's knowledge. The Director of Nursing said they would have expected an investigation conducted to determine how Resident #154's wander guard bracelet was removed on 08/25/2024 and 08/31/2024 (to prevent reoccurance).<br><br>10 NYCRR 415.12(h)(2) |