STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335489	A. Building B. Wing	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morningstar Residential Care Center	17 Sunrise Terrace Oswego, NY 13126

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 37385 Based on record reviews and interviews during the abbreviated survey (NY00341925) the facility did not develop and implement a comprehensive person-centered care plan to meet the resident's medical and nursing needs for 1 of 3 residents (Resident #1) reviewed. Specifically, Resident #1 exhibited frequent exit-seeking behaviors, there were no documented interventions to address their behaviors, the resident exited the building and was found in the parking lot. Findings include: The facility policy, Comprehensive Care Plans, reviewed 3/24/2022 documented: - the facility would provide an individualized, interdisciplinary plan of care for all residents that was appropriate to the residents' needs, strengths, results of diagnostic testing, limitations, and goals. - The plan of care shall be individualized, based on diagnosis, resident assessment, and personal goals of the resident and their family. - The planning of care, treatment, and services shall include care planning based on data collected from assessments with integration of those findings into the care planning process. The facility policy, Elopement/Wandering Risk, revised 3/20/2024 documented: - An assessment will be completed by the Charge Nurse/designee and elopement/unsafe wandering risk will be determined. - Upon completion of the Elopement/Wandering Risk Assessment, the Charge Nurse/designee will initiate/update the Elopement/Wandering Risk Care Plan based upon information/risk factors identified and interventions will be implemented as appropriate. - If a resident is considered high risk for elopement/unsafe wandering, initially and upon change in physical status, a care plan must be initiated with documented interventions. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 had diagnoses including dementia, psychotic disorder with delusions (false beliefs), and history of falls. The 4/4/2024 Admission Minimum Data Set assessment documented the resident had moderate cognitive impairment and did not exhibit wandering behaviors. The Comprehensive Care Plan initiated 3/31/2024 documented: - the resident had impaired cognitive function related to the disease process, schizophrenia, and impaired decision making. Interventions included: simple, structured activities; consistent routine; monitor, document, and report changes in cognition, decision-making, and general awareness; and the resident required supervision with decision-making. - the resident had an activities of daily living self-care performance deficit related to confusion, dementia, and impaired balance. Interventions included supervision for walking with a 4-wheeled walker, walking 5 feet with two turns, supervision and contact guard assistance. - the resident was at risk for falls related to confusion, gait/balance problems, and lack of safety awareness. The resident had falls on 4/5/2024, 4/25/2024, 5/7/2024, and 5/9/2024. Interventions included: safety reminders, anticipate needs, encouragement to participate in activities, and appropriate footwear. The 4/1/2024 Wandering Risk Evaluation completed by Registered Nurse #5 documented the resident was forgetful/had a short attention span, was admitted within the last month, had a caregiver or staff change, was independent with mobility and use of a cane/walker, and took antidepressants and narcotics. The last section Elopement Risk (known wandering, history of wandering, follows visitors out, opens exit doors, exit seeking, potential to learn door codes, or resident is not at risk for unsafe wandering) had no options checked. The risk score was documented as 6 and moderate risk for wandering. The evaluation did not include parameters for interventions based on the score. There were no documented interventions in the Comprehensive Care Plan related to wandering or exit-seeking from 4/1/2024-5/11/2024. The 5/11/2024 Incident Report completed by Licensed Practical Nurse Supervisor #1 documented: - at approximately 5:50 PM, an alarm indicated a door was opened. The alarm panel indicated one of the side doors on the C-wing was opened. - Registered Nurse Supervisor #1 went to Resident #1's room, the resident's wheeled walker was in the room, the resident was not in the room. - The Predisposing Situation Factors included use of a walker and wandering. - A certified nurse aide (unnamed) alerted Licensed Practical Nurse Supervisor #1 that Resident #1 was in the visitor parking lot, leaning against a car. During a telephone interview on 8/19/2024 at 6:30 PM Certified Nurse Aide #2 stated since the resident was admitted (end of 3/2024), they frequently exhibited exit-seeking behaviors. Their behaviors included getting their coat, saying they were leaving, and going to the front and side doors. They were unaware of any specific interventions and was instructed to redirect the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/20/2024 at 10:35 AM Licensed Practical Nurse #18 stated since the resident was admitted they wandered in and out of rooms, the halls, and sometimes went to doors, and the reception area. The resident verbalized all the time they wanted to get their truck, go to work, or go see their brother. The resident would approach the emergency exit doors and looked like they were reading the signs on the door (which says if door held for 15 seconds, it would release). The resident had triggered the door alarm by pushing the bar before 5/11/2024. The exit-seeking behaviors were discussed multiple times at shift reports. They were not certain if the resident had a wander alert device in place prior to 5/11/2024. During an interview on 8/20/2024 at 10:47 AM the Activities Director stated since the resident was admitted , they exhibited exit-seeking behaviors. The resident said things such as they had to get out of there, had to get their truck, go to work, they had to get their brother, and would ask where to get out. The resident went to the doors, sometimes saying they were looking for their spouse. Staff redirected them by offering walks, snacks, or distracting them with conversation. At times it was not difficult to redirect the resident, other times, it required more persuasion. Prior to the resident's elopement on 5/11/2024, they had participated in meetings where the resident's exit-seeking was discussed as related to their confusion. They were unaware of any specific interventions or if the resident had a wander alert device at the time. During an interview on 8/30/2024 at 11:31 AM, Licensed Practical Nurse Unit Manager #17 stated they were responsible for care plans. The interdisciplinary team reviewed them to ensure needed areas were addressed. Updates and revisions were done based on changes in status and new interventions needed. A Wandering Risk Evaluation result of moderate risk meant the resident was actively wandering the building without active attempts to leave and the resident should be care planned for the behavior. Specific interventions would be discussed with the interdisciplinary team. The resident began exit-seeking and wandering close to their admission. The resident wandered about the facility and made verbal statements about leaving. They stated they were unsure of the reason there was no care plan for the resident's wandering behaviors. 10NYCRR 415.11(c)(1)

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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. 37385 Based on record reviews and interviews during the abbreviated survey (NY00341925) the facility did not ensure each resident received adequate supervision to prevent accidents for 1 of 3 residents (Resident #1) reviewed. Specifically, Resident #1 exhibited frequent exit-seeking behaviors, was not supervised, had no care planned interventions in place, and exited the building to the parking lot. Findings include: The facility policy, Elopement/Wandering Risk, revised 3/20/2024 documented: - Assessment would be completed by the Charge Nurse/designee and elopement/unsafe wandering risk would be determined. - Upon completion of the Elopement/Wandering Risk Assessment, the Charge Nurse/designee would initiate/update the Elopement/Wandering Risk Care Plan based upon information/risk factors identified and interventions would be implemented as appropriate. - If a resident was considered high risk for elopement/unsafe wandering, initially and upon change in physical status, a care plan must be initiated with documented interventions. Resident #1 had diagnoses including dementia, psychotic disorder with delusions (false beliefs), and history of falls. The 4/4/2024 Admission Minimum Data Set assessment documented the resident had moderate cognitive impairment, did not exhibit wandering behaviors, required supervision/touching assistance for walking up to 150 feet in a corridor or similar space, partial/moderate assistance for walking 10 feet on uneven surfaces, was dependent for walking 1 step (curb) or multiple steps, and had no falls since admission. The 4/1/2024 Wandering Risk Evaluation completed by Registered Nurse #5 documented the resident was at moderate risk for wandering. The evaluation did not include parameters for interventions to address the risk. Nursing and social work progress notes from 4/1/2024 through 5/10/2024 did not include documentation related to the resident's wandering or exit-seeking. The 5/11/2024 Incident Report completed by Licensed Practical Nurse Supervisor #1 documented: - at approximately 5:50 PM, an alarm indicated a door was opened. The alarm panel indicated one of the side doors on the C-wing was opened. - Licensed Practical Nurse Supervisor #1 went to Resident #1's room, the resident's wheeled walker was in the room, and the resident was not in the room. - The Predisposing Situation Factors included use of a walker and wandering. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A certified nurse aide (unnamed) alerted Licensed Practical Nurse Supervisor #1 that Resident #1 was in the visitor parking lot, leaning against a car. - The resident was confused and stated it was their vehicle and they were going to their brother's. The resident was walked back into the facility and had no noted injuries. - Certified Nurse Aide #2's statement documented they last saw the resident at 5:15 PM walking to their room with another aide. The resident had been more confused and was exit-seeking at the front entrance earlier in the shift. - Certified Nurse Aide #3's statement documented they were with a resident when the alarm went off. They went to the nurse's station and was told Resident #1 had left. They knew it was Resident #1 as Certified Nurse Aide #2 stated they saw the resident out in the parking lot. - Certified Nurse Aide #4's statement documented they were in another room assisting a resident with dinner. The resident's roommate had visitors and the aide did not hear the alarm. The undated, unsigned Investigation Summary documented: - according to statements and video footage reviewed, Resident #1 exited the building from the unit's side exit door to the visitor parking area at 5:54 PM. - The resident was located by staff 2 minutes and 35 seconds following their exit. - The resident was found without their wheeled walker, leaning against a vehicle. - Orders for a urinalysis (a urine test used to detect and monitor health conditions) were obtained and results indicated infection. - The resident was placed on 15-minute visual checks for safety. During an observation on 8/19/2024 at 11:30 AM, Resident #1 was lying on their bed. There was no visible wander alert device on the resident, and they had a walker in their room. During an observation on 8/20/2024 a 2:00 PM, the resident's prior room (where they resided from admission to 8/5/2024) and exit door were observed. The resident's room was located toward the end of the corridor to the left of the main dining room and nurse's station. Their room was 2 doors away from the emergency exit door at the end of the corridor. The door was labeled with signs documenting if the bar on the door was held for 15 seconds, it would release. The door opened to a sidewalk in the front of the building. The visitor parking lot was located approximately 20 to 25 feet to the right. During an observation on 8/20/2024 at 11:46 AM Resident #1 was in the dining area. They were seated in a chair with their walker next to them. There was a wander alert device on their right ankle. The resident stated the device was to make sure they did not go anywhere. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 8/19/2024 at 6:30 PM Certified Nurse Aide #2 stated on 5/11/2024, Resident #1 wandered and exit-seeked most of the second shift (2:00 PM-10:00 PM). Staff redirected the resident throughout the shift. During dinner, they heard one of the door alarms sound. Licensed Practical Nurse #1 checked the side door that led to the courtyard and checked the resident's room and did not see the resident. Certified Nurse Aide #2 went to the window in the dining room and saw the resident outside leaning against a car. They immediately went out to get the resident. Staff had to frequently redirect the resident, and on 5/11/2024, they got busy with dinner and the resident must have taken that opportunity to leave. Licensed Practical Nurse #1 was made aware on 5/11/2024. Certified Nurse Aide #2 stated they were not aware who the supervisor was and did not report to a supervisor about the resident's exit-seeking. During a telephone interview on 8/20/2024 at 9:37 AM Licensed Practical Nurse #1 stated the resident had ongoing exit-seeking behaviors prior to 5/11/2024. Their room was near the emergency exit door, which clearly showed if the handle was held, the door would release. The resident was known to attempt to elope all the time. 5/11/2024 was one of those days when the resident tried to get out and said they had to get to their brother. The nurse was the floor nurse on the unit and the Supervisor for the shift as well. The staff were all aware the resident had been exit-seeking that shift and they all agreed to keep an eye on the resident. Licensed Practical Nurse #1 stated they were giving insulin before dinner and the aides were passing trays when they heard the alarm. They immediately checked the exits and at the same time, a certified nurse aide said they saw the resident outside. They immediately went outside to the resident and had to persuade them to return inside to the facility. During an interview on 8/20/2024 at 10:38 AM, Unit Clerk #19 stated there was no book or list on the unit that identified residents at risk of wandering or elopement. They stated the list was kept only at the reception desk. During an interview on 8/20/2024 at 11:32 AM Certified Nurse Aide #4 stated the resident was always exit-seeking. The resident often went to the doors, saying they had to go to work on their truck, asked for help to get out there, pushed on the doors, and often went to the reception area and front door. Staff redirected the resident with conversation, distraction, asking them to stay for dinner, or offering coffee. On 5/11/2024, the resident was redirected frequently, and was very adamant about leaving. Staff continued to try and distract or redirect them. Licensed Practical Nurse #1 told staff to keep an eye on the resident when exit-seeking was reported. The resident's room was very close to the emergency exit door and the aide did not think that was the best idea. If the resident had been moved away from that door, they may have not noticed it so much. During an interview on 8/30/2024 at 11:31 AM, Licensed Practical Nurse Unit Manager #17 stated the resident began exit-seeking and wandering close to their admission. The resident wandered about the facility and made verbal statements about leaving. The resident did not have a wander alert device prior to their 5/11/2024 elopement. When the resident exhibited active exit-seeking behaviors, the supervisor should be notified, staff should be aware of the resident's location, monitor them, and try to direct them to a common area to be monitored. 10NYCRR 415.12 (h)(2)