

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335569	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/08/2025
NAME OF PROVIDER OR SUPPLIER  Elderwood of Lakeside at Brockport		STREET ADDRESS, CITY, STATE, ZIP CODE  170 West Avenue Brockport, NY 14420	

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 - Minimal harm or potential for actual harm</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>47641</p> <p>Based on observations, interviews, and record review conducted during an Abbreviated Survey (NY00340497) for one (Resident #6) of three residents reviewed, the facility did not ensure adequate supervision and monitoring devices were in place to prevent a resident from elopement (when a resident leaves the facility without supervision creating a potential threat to their health and safety). Specifically, Resident #6 was moderately impaired of cognitive function with a history of wandering and eloped from the facility by walking out the front door. The resident was not found for 42 minutes approximately 0.3 miles away. This is evidenced by the following:</p> <p>The facility policy Elopement - Wandering - Missing Resident, dated 10/08/2018, documented that appropriate safety measures are put into place for residents determined to be at risk for unsafe wandering/elopement.</p> <p>Resident #6 had diagnoses that included cerebral infarction (stroke), cognitive communication deficit, and nicotine dependence. The Minimum Data Set Resident Assessment, dated 03/13/2024, revealed Resident #6 had moderate impairment of cognitive function and was coded as behavior not exhibited for wandering.</p> <p>In an interdisciplinary progress note, dated 04/01/2024, Registered Nurse #1 documented Resident #6 got on the elevator and went down to lobby and out the front door to the gazebo.</p> <p>In an interdisciplinary progress note, dated 04/01/2024, Director of Nursing documented Resident #6's family was notified that a wander guard bracelet (a system put in place to alert the facility that a resident was leaving the facility without supervision at a risk to their safety) was placed on the resident due to attempts to leave the unit and was found in the basement looking for an exit by a staff member.</p> <p>Review of the Comprehensive Care Plan, dated 04/01/2024, revealed Resident #6 was at high risk for wandering/elopement and could walk with or without devices (walker). Interventions included monitoring the resident's whereabouts due to unsafe wandering and use of a wander guard bracelet on their right ankle to alert the facility of any wandering and/or elopement.</p> <p>In a nursing progress note, dated 04/07/2024, Licensed Practical Nurse #1 documented that they took Resident #6 outside and noted that when they entered the elevator, the wander guard bracelet did not alarm. Resident #6 stated they cut the wander guard bracelet off and threw it out.</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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a nursing progress note, dated 04/09/2024, Registered Nurse Manager #1 documented Resident #6 refused to wear the wander guard bracelet on their ankle, so it was placed on the resident's walker.</p> <p>In a therapy progress note, dated 04/15/2024, Physical Therapy Assistant #1 documented Resident #6 had walked 300 feet in therapy.</p> <p>In a nursing progress note, dated 04/26/2024, Licensed Practical Nurse #1 documented they went to administer afternoon medications, could not locate Resident #6 on the unit and notified staff on floor to search for the resident.</p> <p>Review of the facility investigation, dated 04/26/2024 and signed by the Director of Nursing and the Administrator, revealed that on 04/26/2024, Resident #6 exited out of the front entrance at approximately 12:43 PM and that there were several staff who saw the resident, but did not realize they were a resident, or did not realize the resident was not allowed to be outside unsupervised. Resident #6 made their way to a local park across the street from the facility which was approximately 0.3 miles away and was found by staff approximately 40 minutes later.</p> <p>During an interview on 12/06/2024 at 1:39 PM, Certified Nursing Assistant #1 stated Resident #6 had gotten outside to the duck pond and staff had to drive around to find the resident.</p> <p>During an interview on 12/06/2024 at 3:10 PM, Physical Therapist #1 stated Resident #6 became independent with walking without a walker on 04/15/2024 and still liked to use their walker at times, but needed to be supervised when using it as they were not using it correctly.</p> <p>During an interview on 01/08/2024 at 10:58 AM, the Director of Nursing stated Resident #6 had been walking without their walker for some time. The Director of Nursing stated they emailed the Nurse Manager on 04/09/2024 to place the resident on 15-minute checks when the resident refused to wear their wander guard, but the 15-minute checks had not been completed and there was a flaw in their system.</p> <p>During an interview on 01/08/2025 at 1:24 PM, the Administrator stated Resident #6 had not been wearing their wander guard bracelet and like many residents, they looked like a visitor. Resident #6 left the facility at a high traffic time and walked through the lobby when the front desk staff were busy and did not see the resident leave. When therapy deemed the resident independent with walking, the wander guard bracelet should have been on the resident, but the resident had cut it off a few times. The Administrator also stated they thought that the 15-minute safety checks were being completed, but they were not.</p> <p>Based on the following corrective actions it was determined, through interviews and record review, the facility implemented corrective actions to correct the non-compliance effective 05/15/2024:</p> <ul style="list-style-type: none"> <li>- A full house audit was completed for all residents using wander guard bracelets.</li> <li>- Any wander guard bracelets located on adaptive equipment were moved to residents' bodies. Observations of current residents with wander guard bracelets revealed no issues.</li> <li>- Full house staff education was completed regarding wandering and elopement. Interviews with current staff revealed no issues identified.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- An email is sent out to all staff monthly with pictures of residents who are at high risk for elopement.</p> <p>- Binders containing pictures of residents at risk for elopement were placed on all units, the basement, and in the kitchen area for all staff awareness and remain current. Observations of the binders on 01/08/2025 revealed no issues.</p> <p>10 NYCRR 415.12(h)(2)</p>		