STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335603	A. Building B. Wing	12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Schofield Residence	3333 Elmwood Avenue Kenmore, NY 14217

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 00924 Based on interview and record review completed during a complaint investigation (Complaint #NY00317688), the facility did not ensure that each resident received adequate supervision and assistance devices to prevent accidents for two (Residents #1 and #4) of three residents reviewed for accidents. Specifically, Resident #1 and Resident #4 both had dementia with wandering behavior, were not accurately assessed and care planned for wandering/elopement, and subsequently eloped through the front door of the facility. The findings are: Review of the Elopement Risk Assessment policy dated 10/04 revealed an Elopement Risk Assessment Form requires completion within 24 hours of admission, or when newly identified wandering behavior is identified and staff are to review or complete this assessment with each Minimum Data Set/Care Plan review. If the resident is identified at risk, a comprehensive care plan for wandering requires initiation. Review of the policy titled Wanderguard Departure Alert System dated March 2022 revealed residents with independent mobility, restless, and or pacing behavior are risk factors to evaluate for wander guard candidates. The Unit/Coordinator is responsible to assess the resident's need for the device in conjunction with other interdisciplinary team members and should be documented in the medical record. Review of the Receptionist Procedure Book revealed it was the duty of the receptionist to monitor the front door. A list of residents who have wander guards was posted on the wall by the receptionist's phone. In addition, a list of residents that were okay to sit alone outside is also located above the reception phone. If the resident was not on the list, the receptionist was to call the nurses station and determine whether the resident was able to go out alone. 1. Resident #1 had diagnoses including dementia, and obsessive-compulsive behavior. The Minimum Data Set (a resident assessment tool), dated 5/26/2023, documented Resident #1 was severely cognitively impaired, usually understood, and usually understands. Resident #1 required limited assistance of one person for transfers and walking and used a wheelchair for locomotion. The resident exhibited no wandering behavior during the assessment period. (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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the comprehensive care plan initiated on 12/17/2021 revealed Resident #1 had impaired thought processes related to Alzheimer's. Nursing interventions to cue, reorient and supervise the resident as needed were initiated on 12/17/21 and were discontinued on 12/21/21. There was no care plan specific to the resident's impaired cognition and no care plan for wandering and/or elopement risk. Review of the Kardex (guide used by staff to provide care) dated 5/17/2023 revealed Resident #1 could ambulate 750 feet and required the extensive assistance of 1 person for locomotion. The Kardex did not include that the resident was able to self-propel their wheelchair or that they frequently self-ambulated. There was no information regarding the resident's wandering and/or elopement risk. Review of nursing Progress Notes dated 4/1/2023 to 6/3/2023 revealed Resident #1 had wandering behavior documented on 4/11/2023, 4/14/2023, 5/3/2023, 5/4/2023, 5/6/2023, 5/14/2023, 5/28/2023, and 5/31/2023. At times the resident self-ambulated and other times used a wheelchair to wander. Review of a Speech Therapy Progress Note dated 5/15/2023 revealed Resident #1 had moderate deficits in safety awareness and severe deficits in problem solving and reasoning with follow up plans for speech therapy to address short term memory, reasoning, problem solving and safety awareness. Review of the Nursing Routine Care Plan Evaluation for Wandering/Elopement dated 5/26/2023 revealed Resident #1 had cognitive deficits, walked frequently, was on 1-2 psychotropic medications and had 1-2 pertinent diagnosis that would contribute to an elopement risk. There was no scoring system or determination of Resident #1's elopement risk documented based on these findings and no specific care plan interventions were initiated to address the resident's potential for wandering/elopement. The Nursing Home Facility Incident report dated 6/3/2023 revealed on 6/3/2023 at 1:33 PM the receptionist on duty allowed the resident to sign out on the log to go outside the front door. The receptionist stated the resident presented to the desk with two visitors and the receptionist assumed the resident was with the two visitors. A Nursing Assessment was done for Resident #1 and a wander guard was placed on the resident. Review of the Elopement assessment dated [DATE] revealed Resident #1 was walking at the back door entrance and was found by kitchen staff through a camera; the resident's wheelchair was found in the parking lot. The facility documented the resident was not a wanderer, the resident's care plan was followed and there were no predisposing situations which factored into the elopement. The investigation did not identify that Resident #1's care plan was incomplete and lacked wandering/elopement risks and safety interventions based on the Nursing Routine Care Plan Evaluation for Wandering/Elopement completed on 5/26/2023. During an interview on 12/10/2024 at 12:40 PM, Licensed Practical Nurse #1 stated that Resident #1 was very confused and self-propelled around the facility prior to their elopement on 6/3/2023; however, could be easily redirected. Occasionally they would wander into other resident rooms, but they did not recall any exit seeking behavior. During an interview on 12/10/2024 at 12:40 PM, Certified Nursing Assistant #1 stated that Resident #1 was not alert, and they often wandered around the unit going back and forth down the halls self-propelling their wheelchair and was easy to redirect. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/14/2024 at 11:50 AM, the Director of Nursing stated nursing staff were required to perform a wandering/elopement assessment upon admission, with each quarterly care plan and with a significant change in condition. The Director of Nursing stated they were not aware until April 2024 that staff were not consistently performing the evaluations and that the evaluation system in the electronic medical record did not contain a scoring system to determine what the criteria was for a low risk versus a high risk for elopement. All high-risk residents required a wander guard, and a list of wander guard residents was kept at the front desk. The Director of Nursing stated that the evaluation performed on 5/26/2023 identified the resident had some risk for wandering/elopement; however, the scoring system was absent, and it was unknown how this affected the resident's care plan. The Director of Nursing stated that Resident #1 eloped due to an error by the front desk clerk. During a telephone interview on 12/23/2024 at 1:21 PM, the Speech Language Therapist stated that nursing staff made a referral because the resident wandered all over the facility. The Speech Language Therapist stated nursing staff referred residents who required therapy for safety issues. 2. Resident #4 had diagnoses that included severe unspecified dementia, unspecified psychosis and type 2 diabetes mellitus (problem with the way the body regulates the uses of sugar as a fuel). The Minimum Data Set, dated dated dated [DATE] documented Resident #4 was severely cognitively impaired, understood and understands, exhibited no wandering behavior during the assessment period and was able to walk with supervision and use a wheelchair with supervision. Review of Nursing Routine Care Plan Evaluations dated 11/22/2023 and 2/14/2024 revealed Resident #4 had cognitive deficits, walked frequently, wandered aimlessly, was on 1-2 psychotropic medications and had 1-2 pertinent diagnoses and the resident scored 20 points; however, the facility form did not contain scoring criteria to determine a resident's risk level for wandering/elopement based on these findings and score. The comprehensive care plan dated 2/20/2024 documented Resident #4 required supervision with ambulation and did not require a device on the unit; off the unit required a wheelchair. There were no specific care plan interventions initiated to address the resident's potential for wandering/elopement identified in the Nursing Routine Care Plan Evaluation completed on 2/14/2024. Review of the Nursing Home Facility Incident Report dated 4/26/2024 at 2:11 PM, revealed on 4/21/2024 at 9:35 PM, Resident #4 walked to the front door of the building and pushed on the front entrance door long enough for the lock to release and activated the door alarm. The resident turned around to re-enter the building, but the door locked, and she walked to the next door and tried to enter the building. Staff responded to the alarm and brought the resident back into the building. A wander guard was placed on the resident after the incident. Review of the Elopement assessment dated [DATE], completed after the incident, documented the resident had impaired memory, was confused, was a wanderer and had a recent room change and determined the resident's care plan was followed. The investigation did not identify that Resident #4's care plan was incomplete and lacked the resident's wandering/elopement risk and safety interventions specific to their cognitive and locomotion abilities. During an interview on 12/10/24 at 8:30 AM, Licensed Practical Nurse #3 stated Resident #4 was currently very confused and had a wander guard on. Licensed Practical Nurse #3 stated that Resident #4 had always been very confused and mobile throughout the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/11/2024 at 9:50 AM, the Licensed Practical Nurse #4 Unit Manager stated Resident #4 had dementia, had always been confused and was able to ambulate and self-propel in a wheelchair. The Licensed Practical Nurse #4 Unit Manager stated Resident #4 had sundown syndrome (increased confusion, agitation and other behavior changes that happen in the late afternoon or evening) and frequently walked around the unit and required redirection; however, they didn't believe the resident exhibited wandering behavior because the resident did not look distressed and liked ambulating. During an interview on 12/11/2024 at 12:30 PM, the Licensed Practical Nurse #4 Unit Manager stated that elopement and wandering assessments were done quarterly with care plan evaluations; and stated if something triggered a wandering/elopement evaluation tool contained in the electronic care plan an evaluation would be performed to assess the resident. The Licensed Practical Nurse #4 Unit Manager could not provide any additional specific information on the facility policy related to wandering/elopement. During an interview on 12/10/2024 at 1:15 PM, the Director of Nursing stated that after Resident #4's elopement it became apparent that staff were not routinely performing wandering/elopement assessments and that a scoring system with defined risk criteria was not utilized for the tool that captured at risk behaviors for wandering/elopement. The Director of Nursing stated that Resident #4 had known wandering behavior documented prior to the 4/21/2024 elopement. 10 NYCRR 415.12(h)(2)