| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395690 | A. Building<br>B. Wing | 09/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Springfield Rehabilitation and Healthcare Center | 463 West Sproul Road<br>Springfield, PA 19064 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0623<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>36609<br><br>Based on interviews with staff and review of facility documentation determined the facility failed to notify a representative of the Office of the State Long-Term Care Ombudsman of residents' transfers and/or discharges in writing for 2 of 2 months reviewed (July and August 2024).<br><br>Findings include:<br><br>Review of facility's documentation of the list of residents transferred or discharged from the facility in the month of July 2024 revealed the Office of the State Long-Term Care Ombudsman did not receive a copy of the notice sent to the resident and/or the resident's representative before these transferred or discharges occurred.<br><br>28 Pa. Code 201.14(a) Responsibility of licensee<br><br>28 Pa. Code 201.18(b)(2) Management |

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 - Immediate jeopardy to resident health or safety<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36609<br><br>Based on review of clinical records, facility documentation and policy, and interviews with staff, it was determined the facility failed to provide adequate supervision to Resident R1 with a history of wandering, and at risk for elopement. This failure resulted in an Immediate Jeopardy situation to Resident R1 who eloped from the facility, crossed a high traffic street and was found by a member of the community in a lot across from the facility entrance, for one of four residents reviewed at risk for elopement (Resident R1). The deficiency was identified as Immediate Jeopardy past non-compliance.<br><br>Findings include:<br><br>Review of the facility's policy titled, Wander Management and Elopement Prevention updated March 2022, states, The facility will maintain the safety of residents who wander and/or are at risk for elopement. The staff will identify residents who are at risk for harm because of unsafe wandering (including elopement). The staff will implement a wander management system device as part of the plan of care. Resident care plan will include specific interventions to ensure safe wandering and prevent elopement. The wander management system device will be used in conjunction with other resident specific interventions for the management of unsafe wandering. When implementing a wander management system device, the staff will implement routine checks for placement each shift and functionality daily. Identified issues with wander management system device placement or functionality will be immediately addressed with replacement of the device.<br><br>Review of Resident R1's clinical record revealed an admitted [DATE], diagnosed with Unspecified Dementia (progressive degenerative disease of the brain), severe without behavioral disturbances, psychotic disturbance, mood disturbance, anxiety, and abnormal finding on diagnostic imaging of skull and head not elsewhere classified.<br><br>Review of Resident R1's admission Minimum Data Set (MDS- assessment of residents' needs), dated July 17, 2024, revealed the resident had no impairments to his upper and lower body and had the ability to walk at least 150 feet with supervision or touch assistant (verbal cues) and needed partial/moderate assistance (helper does less than half the effort) for activities of daily living.<br><br>Review of Resident R1's admission evaluation dated, July 11, 2024, assessed the resident as an elopement risk, indicating that the resident was cognitively impaired with poor decision-making skills, diagnosed with dementia, and ambulating independently without the use of an assistive devise. The same evaluation assessed the resident's behaviors, indicating that the resident showed signs of being easily distracted; had periods of altered perception or awareness of his surroundings; episodes of disorganized speech; periods of restlessness; periods of lethargy; mental function that varied over the course of the day; wandered; abusive and resisted care and ambulated with an unsteady gait.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Due to Resident R1's risk of elopement, on August 12, 2024, orders were obtained for the resident to wear a Wander Guard Bracelet (device that is place on ankle or wrist that activates the locking mechanism on doors to the outside of the facility) instructing to check the function and placement of the bracelet every shift. A care plan was also developed that included interventions to engage the resident in activities to decrease wandering, and to evaluate the resident's desire to leave.<br><br>Review of documentation submitted to the Department of Health indicated that on, August 29, 2024, at approximately 6:30 p.m., two charge nurses from different units discussed the whereabouts of Resident R1; at the same time someone in the community called to inform the facility that Resident R1 was found off the facility's property, across the street. The same report noted that the resident did not have the wander guard in place when he was found.<br><br>Review of Resident R1's facility incident report revealed on August 29, 2024, on the 11-7-night shift, Licensed Practical Nurse, Employee E4, checked and documented the wander guard for placement and realized Resident R1 was not wearing it. During an interview with Licensed Practical Nurse (LPN), Employee E4 on September 11, 2024, at approximately 2:30 p.m. stated the resident was sleeping and did not want to wake him. Before the end of the shift the nurse checked for placement and did not see the wander guard. She documented in the resident's electronic medication administration record an X for not being able to verify placement and left the facility without telling the supervisor. The nurse continued to say I thought someone would see the note, but I was re-educated. I know now to immediately report to a supervisor if a wander guard is missing from a resident.<br><br>Continued review of facility documentation and observation and interview with the Director of Nursing (DON) on September 10, 2024, at 2:00 p.m. revealed the facility investigation determined Resident R1 was last seen at 6:10 p.m. and the facility felt the resident left the unit through closed double doors. The facility investigation revealed the armature of the door loosened when the resident used force to pull on the door. The DON explained the doors now have been replaced with a Mag lock (an electromagnetic force to stop doors from opening). The facility surmised the resident then proceeded to pass the reception desk at a time when no one was supervising the area, walked out the front door, through the parking lot, then crossed a high traffic- two lane street and was later found nearby.<br><br>An Immediate Jeopardy template (a document which included information necessary to establish each of the key components of immediate jeopardy) was provided to the Nursing Home Administrator on September 11, 2024, at 1:59 p.m. The facility failed to ensure adequate supervision was provided to Resident R1 who was diagnosed with dementia and was at risk for elopement. Resident R1 was able to eloped from the facility, and crossed a high traffic street.<br><br>The facility provided their immediate action plan on September 11, 2024, which they had begun implementing on August 29, 2024 immediately after the incident occurred, to address the failure of providing inadequate supervision for an ambulatory resident who displayed signs of wandering, and elopement. The facility's plan of correction included the following:<br><br>1. The resident is not currently at the Center. The resident returned to the Center from the hospital with an abrasion to right knee. All other studies were within normal limits. Completed on August 30, 2024.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 2. RN Supervisor on August 29th completed a headcount of all residents and compared it to the midnight census to ensure all residents were accounted for and resting comfortably, Variances identified included discharged residents. Completed on August 29, 2024.<br><br>3. Immediate Actions/Education<br><br>-The Nursing Administrator reviewed all resident EHR (Electronic Health Record) for accurate elopement/wandering evaluations, orders for every shift placement checks, daily function tests and care plans. Elopement books found at reception desk and on every unit were reviewed to ensure that all residents identified as elopement risks were current and resident identifiers were available. Completed on August 29, 2024.<br><br>-Nursing Staff were educated on if they find an identified resident without an elopement device, supervision is established for the resident, another device is located and applied. If the device cannot be reapplied, 1:1 supervision is maintained. The DON/designee will be notified immediately. Achieved 94% on 8/30/2024. The remainder will be educated PRIOR to the next shift scheduled. Remainder completed on 9/4/2024.<br><br>-Review of Center elopement drills for completeness and staff participation. Plant Operations provided elopement drills held monthly for the last quarter. Completed 8/30/2024.<br><br>-RN supervisors were educated on completion of headcount of all residents compared to midnight census and the immediate reporting of any discrepancy to the Director of Nursing/designee. Achieved 100% on 8/30/2024.<br><br>-Reception/off shift staff were educated on the process of each visor receiving a badge that must be returned prior to door being open and visitor leaving the premises, Achieved 94% on 8/29/2024. The reminder will be educated PRIOR to the next shift scheduled. Remainder completed on 9/4/2024.<br><br>-Staff educated on elopement/missing person policy and procedures including code yellow announcement to notify staff in Center, search both on the premises and the surrounding areas notification process including local police department. Achieved 94% on 8/30/2024. The remainder will be educated PRIOR to the next shift. Scheduled, Remainder completed on 9/4/2024.<br><br>-Staff educated on elopement drills including how often and expected response. Achieved 94% on 8/30/2024. The remainder will be educated PRIOR to the next shift scheduled. Remainder completed on 9/4/2024.<br><br>Reception staff were educated on the need for constant supervision of the front reception area. The RN supervisor/designee is to be notified of relief prior to leaving area. Achieved 100% on 8/30/2024.<br><br>-The double door leading out of unit will be modified to include a mag lock on both doors. Parts have been ordered and will be added/installed upon receipt. Double doors were monitored via 1:1 until mag locks were installed on 9/6/24.<br><br>All the training above will be added to our general orientation schedule for all future new employees. Completed 8/30/2024.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 4. Ongoing Compliance will be monitored by:<br><br>-Auditing census compared to headcount every 4 hours for 3 days then every 8 hours for 3 days then every shift for 14 days then daily.<br><br>-Random audit of five visitors to ensure compliance to pass system two times daily for 14 days then daily.<br><br>The facility action plan was accepted on September 11, 2024, at 4:48 p.m. and identified as past non-compliance.<br><br>Review of facility documentation revealed that the corrective plan was immediately developed and initiated on August 29, 2024, revealing 94% was accomplished on the first day, and fully complete on September 6, 2024.<br><br>On September 11, 2024, interviews with nursing staff and staff from multiple departments revealed they were able to verbally demonstrate their knowledge of the elopement trainings and verbally proved they understood the importance of following the facility's policies and procedures to ensure the safety of the residents.<br><br>The Immediate Jeopardy was lifted on September 11, 2024 at 4:48 p.m.<br><br>28 Pa. Code 211.10(c) Resident Care policies<br><br>28 Pa. Code 211.12(d)(1) Nursing services<br><br>28 Pa. Code 211.12(d)(5) Nursing services |