

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415059	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2024
NAME OF PROVIDER OR SUPPLIER Orchard View Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 135 Tripps Lane East Providence, RI 02915	

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 - Immediate jeopardy to resident health or safety</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48928</p> <p>Based on record review and staff interview it has been determined that the facility failed to ensure a resident receives adequate supervision to prevent accidents for 1 of 4 residents reviewed who successfully eloped from the facility and for whom interventions and assessments were not implemented, Resident ID #4.</p> <p>Findings are as follows:</p> <p>Record review of a community reported complaint submitted to the Rhode Island Department of Health on 4/18/2024 alleges that Resident ID #4 had eloped from the facility successfully twice.</p> <p>Review of the facility policy titled Elopement states in part, .Elopement is defined as the ability of a resident who is not capable of protecting himself or herself from harm to successfully leave the facility unsupervised and unnoticed and who may enter into harm's way .</p> <ul style="list-style-type: none"> - The licensed nurse will conduct an elopement screen on admission, re-admission, annually, upon change of condition. Residents identified at risk for elopement will have their photo maintained in a confidential manner at the main entrance to the facility. - A care plan will be developed and implemented for any resident at risk of elopement . <p>Review of a facility policy titled Discharge Against Medical Advice (AMA) states in part, .Procedure (MA/RI) .</p> <ul style="list-style-type: none"> - An order for AMA will be written. - Documentation will be made in the clinical record with details of the discharge to include persons notified, statement of reason for discharge, if known, the date and time of discharge. - The resident/patient and or legal representative will sign the AMA form and it will be placed in the clinical record. - Appropriate agencies will be notified by the Social Worker or member of center to provide additional services to the resident, if necessary, in the community . <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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review revealed the resident was admitted to the facility in September 2023 with diagnoses including, but not limited to, schizoaffective disorder, adjustment disorder, traumatic brain injury, developmental delay, mild intellectual disability, and type 2 diabetes mellitus.</p> <p>Record review of a document titled Psychiatric Evaluation and Consult dated 2/1/2024, revealed the resident has, .schizoaffective disorder, bipolar type .[S/he] demonstrated AVH [auditory verbal hallucinations] and paranoia at today's visit but did not appear as agitated as last visit. I will continue to monitor. Mild-intellectual disability may complicate medication teaching .</p> <p>1a. Record review of a progress notes revealed on 2/2/2024, the resident went to a behavioral health appointment in the community. Additional review of this progress note revealed that s/he was accompanied by facility staff, Nursing Assistant (NA), Staff A, and that the resident ran out of the provider's office. Staff A and the staff at the provider's office pursued the resident but were unable to reach him/her as s/he fled the building. The note further revealed that the facility assumed the resident left AMA, the resident's family was contacted and it was indicated that if the resident were to be found, s/he would need to go to the Emergency Department to be medically cleared before s/he could return to the facility, as the resident has a history of substance abuse.</p> <p>Review of a statement authored by Staff A on 2/2/2024 states, I went in to the appointment with the resident, while we were in the waiting room, [s/he] started to get aggravated saying [s/he] 'was going to leave and if the cops came looking for [him/her], [s/he] would kick their a**,' [s/he] was pacing back and forth. The doctor came and took us into her office, the resident wasn't answering her questions she was asking [him/her]. [S/he] just kept saying 'I don't want to talk about it' She was trying to find out what was bothering [him/her], then [s/he] stood up and took off out the door. The doctor followed [him/her] trying to redirect [him/her], but [s/he] had left the building. Cops were called and I gave my description of [him/her].</p> <p>During a surveyor interview with Staff A on 4/19/2024 at 10:50 AM, she indicated that she usually accompanies residents that are not alert and oriented to their appointments. Additionally she indicated that she was asked to accompany Resident ID #4 to his/her behavioral health appointment in the community on the morning of 2/2/2024. She further revealed that the doctor's office called the local police department to locate the resident as they were unable to find him/her after s/he ran off.</p> <p>During a surveyor interview with Registered Nurse (RN), Staff B, on 4/19/2024 at approximately 2:15 PM, she revealed that on 2/2/2024 at approximately 4:00 PM, she was looking out the window and happened to see the resident outside of the facility with Emergency Medical Services (EMS). Staff B indicated that this was the first time that the resident was seen at the facility after running out of the doctor's office that morning. Staff B acknowledged it was unclear how the resident made it back to the facility. EMS informed her that the resident had called 911, and they were taking him/her to the hospital. She further revealed that the resident informed her that s/he was made aware by his/her sister, that in order for him/her to be able to return to the facility, s/he needed to go to the hospital for medical clearance first.</p> <p>Record review of a document titled RI EMS Patient Care Report dated 2/2/2024 at 4:03 PM indicated the resident was agitated standing outside the nursing home. A nurse reported the resident is eloping from nursing home. The resident is at the nursing home due to his/her inability to self-medicate properly, and that s/he has a history of schizoaffective disorder, traumatic brain injury, bipolar disorder, and diabetes.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of a document titled Continuity of Care Consultation and Referral Form dated 2/2/2024, revealed the resident eloped from [provider's office] after refusing to participate in [his/her] appointment with psychiatrist. The local Police have been informed and will attempt to locate the client and bring [him/her] to the ED [Emergency Department] for further evaluation.</p> <p>During a surveyor interview with the Director of Nursing Services (DNS), in the presence of Staff B, on 4/19/2024 at approximately 2:20 PM, she unable to explain how the resident returned to the facility on [DATE], s/he fled from the provider's office, approximately 6.7 miles away from the facility. Additionally, she was unable to explain where the resident had been for approximately 6 hours from the time after s/he fled from the provider's office unsupervised and presented him/herself back to the facility.</p> <p>During a surveyor interview with Staff A on 4/22/2024 at 11:30 AM, she revealed she was unaware if the resident had a cell phone or wallet on him/her at the time s/he fled from the provider's office on 2/2/2024.</p> <p>During a surveyor interview with the Regional Director of Nursing (RDNS), on 4/19/2024 at approximately 11:10 AM, in the presence of the DNS, she revealed that on 2/2/2024, the resident left the provider's office of his/her own will and that s/he is alert and oriented, therefore it was her interpretation that the resident had left AMA from the facility and had not in fact eloped. Additionally, she was also unable to provide evidence of a completed AMA discharge from the facility nor was she able to provide evidence that an Elopement & Wandering Risk Assessment had been completed for the resident following the above-mentioned incident when s/he was left unsupervised in the community.</p> <p>Record review failed to reveal evidence that the facility analyzed the events of 2/2/2024 or discharged the resident AMA on 2/2/2024. As the resident's record did not contain an order for an AMA discharge, documentation was not found in the clinical record with details of such a discharge to include persons notified, statement of the reason for discharge was not documented, the date and time of discharge was not documented, the resident or his/her legal representative had not signed an AMA form, an AMA form was not found in his/her clinical record, appropriate agencies were not notified by the Social Worker or a member of the facility to provide additional services to the resident, per the facility's AMA policy.</p> <p>Record review of a document dated 3/18/2024, titled Elopement & Wandering revealed the resident was not at risk for elopement, despite the above-mentioned incident that took place on 2/2/2024 with police involvement.</p> <p>Record review of the resident's care plan failed to reveal evidence that s/he was assessed for elopement risks or that interventions were put in place as a result of the incident on 2/2/2024.</p> <p>1b. Record review of a progress note dated 4/6/2024 revealed the resident had called 911 and walked by the nurse stating, I'm leaving and I'm not coming back. The nurse then watched the resident leave the premises and then the nurse informed her supervisor.</p> <p>Record review of a document titled Orchard View Manor Security Log dated 4/6/2024 through 4/7/2024, revealed that on 4/6/2024, at 7:50 PM, the resident walked out of the building and was heading towards [NAME] farms on Wampanoag Trail, a [nurse] and [security guard] tried to get [him/her] to come back but [s/he] refused. [Nurse] called the police and they took [him/her] to the hospital.</p> <p>(continued on next page)</p>		

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