

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 09/12/2024
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41542</p> <p>Based on surveyor observation, record review and staff interview, it has been determined that the facility failed to keep a resident free from neglect for 1 of 1 resident reviewed who attempted suicide, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Record review of a community reported complaint submitted to the Rhode Island Department of Health on 9/9/2024 alleges that Resident ID #1 tried to commit suicide on 9/7/2024. S/he had a belt around his/her neck and the family was not informed.</p> <p>Review of a facility policy titled, Suicide Attempt or Threats last revised in November of 2019 states in part, In the event a resident/patient attempts or is threatening suicide: Take all allegations seriously. Ensure the resident's/patient's immediate safety. Place the resident on 1:1 [constant supervision]. The charge nurse will notify the supervisor and attending physician. The supervisor or charge nurse will notify nursing administration. A staff member will be assigned to stay with the resident/patient on a one-to-one basis until the resident/patient is seen by psychiatry or sent to the Emergency Department. The staff member must be in close proximity to the resident/patient. Do not leave the resident/patient alone .</p> <p>Record review revealed that the resident was admitted to the facility in June of 2024 with diagnoses including, but not limited to, vascular dementia (dementia caused by a series of strokes that restricts blood flow to the brain) with agitation, depression, insomnia, and chronic post-traumatic stress disorder (PTSD).</p> <p>Review of a Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status Score of 12 out of 15 indicating, moderate cognitive impairment.</p> <p>Review of a progress note dated 9/7/2024 at 7:39 AM states in part, resident had a sleepless night . Resident was found later with belt tied to [his/her] neck, it took three of us to take it from [him/her].</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 415059
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a surveyor interview on 9/10/2024 at approximately 9:00 AM with the Day Nursing Supervisor, Staff A, she revealed she was aware of the resident's suicide attempt that was made during the early morning hours of 9/7/2024. She revealed that the resident was on frequent checks on 9/7/2024, but not on one-to-one supervision. Additionally, she revealed that the resident's family member called the unit on 9/7/2024 at approximately 10:00 -10:30 AM, after the family member had spoken to the resident. The resident told the family member that s/he tried hanging him/herself overnight. The family member was questioning what the resident had just told them and called the facility to confirm. The family member spoke with Staff A, who confirmed what occurred overnight to the caller and told them that the facility wanted to send the resident out for a psychiatric evaluation. The caller then requested that the facility wait to send the resident out because they were on their way. Staff A further indicated that she checked the room for safety and when asked what the room check entailed, she revealed that she checked the room for sharp objects.</p> <p>During a surveyor interview on 9/10/2024 at 10:36 AM with the Night RN/Nursing Supervisor, Staff D, she revealed that the resident's room is directly across from the nurse's desk and that on the evening of 9/6/2024 into 9/7/2024, the resident was awake, in and out of his/her room, and very restless. Staff D indicated that between 2:00 AM and 3:00 AM, the resident came out of his/her room with a belt wrapped around his/her neck. Staff D indicated that she immediately approached the resident and called for help as she tried removing the belt from around the resident's neck. She revealed that it took three staff members to get the resident to release the belt from his/her neck. Additionally, she revealed that following the incident, the resident was placed on frequent safety checks and not on one-to-one supervision as stated in the facility's Suicide Attempts or Threats policy. Staff D indicated that she did not notify the resident's physician, the Director of Nursing (DON), or the resident's family. Furthermore, she acknowledged that she did not send the resident to the Emergency Department for a psychiatric evaluation following his/her suicide attempt.</p> <p>During a surveyor interview on 9/10/2024 at approximately 9:15 AM with Nursing Assistant (NA), Staff B, she revealed that on 9/7/2024 between 2:00 AM and 3:00 AM, she heard the nurse calling out that Resident ID #1 had a belt around his/her neck and that help was needed. Staff B indicated that it took three staff members (including herself) to talk the resident into releasing the belt and handing it to them. Additionally, Staff B revealed that she took the belt and placed it back in one of the resident's drawers where other belts were located. Staff B indicated she kept the resident safe the remainder of the shift by checking his/her room for sharp objects like scissors and razors and that the resident was checked on a lot. Staff B indicated the resident was not provided with one-to-one supervision.</p> <p>During a surveyor interview with Licensed Practical Nurse, Staff C, on 9/10/2024 at 10:50 AM, she revealed that the resident attempted to hang him/herself on the 11:00 PM to 7:00 AM shift on 9/7/2024 and was placed on frequent checks but was not on one-to-one supervision.</p> <p>Record review failed to reveal evidence that, per their facility policy, the resident was placed on one-to-one supervision, that the charge notified the physician and/or nursing administration, that a staff member was assigned to stay with the resident on a one-to-one basis until s/he was sent to the emergency room , and that the responsible party/family was notified.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a surveyor interview with the resident's family member on 9/11/2024 at approximately 9:30 AM, she revealed that she arrived at the facility at approximately 12:30 PM on 9/7/2024 and that she observed the resident crossing the parking lot without his/her walker. The resident was alone without a staff member present and greeted her at the car. Additionally, she revealed the resident was wearing a belt after having attempted to hang him/herself with a belt earlier that morning.</p> <p>During a surveyor interview on 9/11/2024 at approximately 1:00 PM with Staff E, Social Worker, she revealed that she saw the resident on 9/7/2024 when she arrived at work on 9/7/2024 between 10:00 -11:00 AM. Staff E revealed that the resident was outside alone, unattended by a staff member. She immediately went up to the resident's unit to notify the nurse, Staff C, who then sent a restorative aid outside to get him/her. Additionally, she indicated that she called the DON to report her findings of the resident being outside alone, indicating that the facility was not aware of the resident's whereabouts after s/he had attempted suicide earlier that morning.</p> <p>During a surveyor observation of the resident's room on 9/11/2024 at approximately 12:45 PM, the following was identified, resident's closet and dresser contained several pairs of shorts/pants and jackets with removable string ties. The resident's call light was attached to the resident's bed side rail and a phone with a long phone cord was observed on the resident's bedside table.</p> <p>Review of the facility's surveillance footage of 9/7/2024, in the presence of the Administrator, DON, and Assistant Director of Nursing (ADON), revealed the following occurrences:</p> <ul style="list-style-type: none"> - 2:48 AM to 2:57 AM- The resident was observed ambulating in and out his/her room multiple times. S/he was also observed to sit in a chair for a few moments but then would get up. - 2:58 AM- The resident came out of his/her room with a belt wrapped around his/her neck and proceeds to sit in a chair outside of his/her room, visible from the nurse's station. Staff D approaches the resident and attempts to remove the belt. - 2:59 AM- Two NAs arrived to help the nurse remove the belt from the resident's neck. The NAs and Staff D were then observed walking the resident back into his/her room. - 3:00 AM to 7:00 AM- Revealed staff intermittently would enter and exit the resident's room. - 10:40 AM- Revealed the resident exiting the facility unattended and then goes out of view. - 11:15 AM - The Resident was observed walking back into the facility with the restorative aid. - 12:28 PM- The Resident was observed exiting the facility a second time unattended with his/her walker, crossing the parking lot and approached a parked car. The resident and his/her family member, who was in the parked car, then made their way to and sat at a picnic table until 1:44 PM. They were then observed entering the facility together. The resident was observed wearing a belt. - 2:20 PM- The Resident was observed being brought out of the facility to an ambulance. <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a follow-up surveyor interview on 9/12/2024 at approximately 10:45 AM with Staff C, after the surveyor had viewed the surveillance footage, she acknowledged that the first time the resident was observed outside at approximately 10:40 AM, she realized the resident was missing and asked a restorative aid to search for him/her. She revealed that the second time the resident was observed outside at approximately 12:28 PM, she was not aware of his/her whereabouts.</p> <p>During a surveyor interview with the DON on 9/10/2024 at 9:45 AM, she revealed that she was not made aware of the events that occurred with Resident ID #1 on 9/7/2024 until approximately 10:00-10:30 AM, 7 hours after the incident had occurred. She indicated that she directed the staff to perform frequent checks until they sent the resident out to the hospital for a psychiatric evaluation. Furthermore, she revealed that she was initially unaware of the facility's Suicide Attempt or Threats policy and unaware of the unsafe items that remained in the resident's room, prior to him/her being sent to the hospital. Additionally, the DON acknowledged that the facility failed to place the resident on one-to-one supervision, notify the physician and/or nursing administration, assign a staff member to stay with the resident on a one-to-one basis until s/he was sent to the emergency room, and notify the responsible party/family of the incident.</p> <p>The facility failed to keep the resident free from neglect as evidenced by:</p> <ul style="list-style-type: none"> - the failure to follow their own Suicide Attempt or Threats policy by not placing the resident on one-to-one supervision until s/he was sent to the hospital, notifying the physician and/or nursing administration, and notifying the responsible party/family of the incident. - the failure of staff members caring for the resident to identify that the cords, belts and ties in the resident's room were potential hazards and were left accessible to a resident who had just had a belt around his/her neck. - the failure to monitor the resident's whereabouts after making a suicide attempt, as s/he was observed outside of the facility unsupervised twice on the same day of the incident. <p>These failures had the potential to place the resident at risk for more than minimal harm, death, or impairment.</p> <p>Cross reference F689</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>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** 41542</p> <p>Based on surveyor observation, record review and staff interview it has been determined that the facility failed to ensure that residents receive adequate supervision for 1 of 1 resident reviewed who attempted suicide, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Record review of a community reported complaint submitted to the Rhode Island Department of Health on 9/9/2024 alleges that Resident ID #1 tried to commit suicide on 9/7/2024. S/he had a belt around his/her neck and the family was not informed.</p> <p>Review of a facility policy titled, Suicide Attempt or Threats last revised in November of 2019 states in part, In the event a resident/patient attempts or is threatening suicide: Take all allegations seriously. Ensure the resident's/patient's immediate safety. Place the resident on 1:1 [constant supervision]. The charge nurse will notify the supervisor and attending physician. The supervisor or charge nurse will notify nursing administration. A staff member will be assigned to stay with the resident/patient on a one-to-one basis until the resident/patient is seen by psychiatry or sent to the Emergency Department. The staff member must be in close proximity to the resident/patient. Do not leave the resident/patient alone .</p> <p>Record review revealed that the resident was originally admitted to the facility in June of 2024 with diagnoses including but not limited to; chronic post-traumatic stress disorder, vascular dementia with agitation, major depressive disorder, insomnia and depression.</p> <p>Review of the Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 12 out of 15, indicating that s/he has moderate cognitive impairment.</p> <p>Review of a care plan dated 6/26/2024 revealed the resident has a history of major depression and post-traumatic stress disorder (PTSD). Interventions include but are not limited to, provide emotional support as needed, encourage verbalization, and psychiatric consult or follow up as needed.</p> <p>Review of a progress note dated 9/7/2024 at 7:39 AM states in part, resident had a sleepless night .Resident was found later with belt tied to [his/her] neck, it took three of us to take it from [him/her].</p> <p>During a surveyor interview on 9/10/2024 at approximately 9:00 AM with the Day Nursing Supervisor, Staff A, she revealed that she was aware of the resident's suicide attempt that was made during the early morning hours of 9/7/2024. She revealed that the resident was on frequent checks on 9/7/2024, but not on one-to-one supervision.</p> <p>Record review failed to reveal evidence that Resident ID #1 was placed on one-to-one supervision per the facility's policy or frequent checks, as indicated by Staff A.</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>During a surveyor interview on 9/10/2024 at 10:36 AM with the Night RN/Nursing Supervisor, Staff D, she revealed that the resident's room is directly across from the nurse's desk and that on the night of 9/6/2024 into 9/7/2024, the resident was awake, in and out of his/her room, and very restless. Staff D indicated that between 2:00 AM and 3:00 AM, the resident came out of his/her room with a belt wrapped around his/her neck. Staff D indicated that she immediately approached the resident and called out for help as she tried removing the belt from around the resident's neck. She revealed that it took three staff members to get the resident to release the belt from his/her neck. Additionally, she revealed that following the incident, she did not place the resident on one-to-one supervision and instead placed him/her on frequent safety checks.</p> <p>Record review failed to reveal evidence that Resident ID #1 was placed on one-to-one supervision per the facility's policy or frequent checks, as indicated by Staff D.</p> <p>During a surveyor interview on 9/10/2024 at approximately 9:15 AM with Nursing Assistant (NA), Staff B, she revealed that on 9/7/2024 between 2:00 AM and 3:00 AM, she heard the nurse calling out that Resident ID #1 had a belt around his/her neck and that help was needed. Staff B indicated that it took three staff members (including herself) to talk the resident into releasing the belt and handing it to them. Additionally, Staff B revealed that she took the belt and placed it back in the resident's drawer where other belts were located. Staff B indicated she kept the resident safe the remainder of the shift by checking his/her room for sharp objects like scissors and razors and that the resident was checked on a lot. Staff B indicated the resident was not provided with one-to-one supervision.</p> <p>Record review failed to reveal evidence that Resident ID #1 was placed on one-to-one supervision per the facility's policy or checked on a lot, as indicated by Staff B.</p> <p>During a surveyor interview with Licensed Practical Nurse, Staff C, on 9/10/2024 at 10:50 AM, she revealed that the resident attempted to hang him/herself on the 11:00 PM to 7:00 AM shift on 9/7/2024 and was placed on frequent checks but was not on one-to-one supervision.</p> <p>Record review failed to reveal evidence that Resident ID #1 was placed on one-to-one supervision per the facility's policy or was placed on frequent checks, as indicated by Staff C.</p> <p>Record review failed to reveal evidence that, per the facility policy, the resident was placed on one-to-one supervision, the charge notified the physician and/or nursing administration, a staff member was assigned to stay with the resident on a one-to-one basis until s/he was sent to the emergency room, and that the responsible party/family was notified.</p> <p>During a surveyor interview with the resident's family member on 9/11/2024 at approximately 9:30 AM she revealed that she arrived at the facility at approximately 12:30 PM on 9/7/2024 and that she observed the resident crossing the parking lot without his/her walker. The resident was alone without a staff member present and greeted her at the car. Additionally, she revealed the resident was wearing a belt after attempting to hang him/herself with a belt earlier that morning.</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>During a surveyor interview on 9/11/2024 at approximately 1:00 PM with Staff E, Social Worker, she revealed that she saw the resident on 9/7/2024 when she arrived at work on 9/7/2024 between 10:00 -11:00 AM. Staff E revealed that the resident was outside and unattended by a staff member. She immediately went up to the resident's unit to notify the nurse, Staff C, who then sent a restorative aid outside to return the resident into the facility. Additionally, she indicated that she called the DON to report her findings of the resident being outside alone, indicating that the facility was not aware of the resident's whereabouts after s/he had attempted suicide earlier that day.</p> <p>A surveyor observation of the resident's room on 9/11/2024 at approximately 12:45 PM revealed the resident's drawers and closet contained several pairs of shorts/pants and jackets with removable string ties. The resident's call light was attached to the resident's bed side rail and a phone with a long phone cord was observed on the resident's bedside table.</p> <p>Review of the facility's surveillance footage of 9/7/2024, in the presence of the Administrator, DON, and Assistant Director of Nursing (ADON), revealed the following occurrences:</p> <ul style="list-style-type: none"> - 2:48 AM to 2:57 AM- The resident was observed ambulating in and out his/her room multiple times. S/he was also observed to sit in a chair for a few moments but then would get up. - 2:58 AM- The resident came out of his/her room with a belt wrapped around his/her neck and proceeds to sit at a chair outside of his/her room which was visible from the nurse's station. Staff D approached the resident and attempts to remove the belt. - 2:59 AM- Two NAs arrived to help the nurse to remove the belt from the resident's neck. The NAs and Staff D were then observed walking the resident back into his/her room. - 3:00 AM to 7:00 AM- Revealed staff intermittently enter and exit the resident's room. - 10:40 AM- Revealed the resident exiting the facility unattended and is out of line of sight of facility staff. Indicating, s/he was not receiving any supervision at that time. - 11:15 AM - The Resident was observed walking back into the facility with the restorative aid. - 12:28 PM- The Resident was observed exiting the facility a second time unattended with his/her walker, crossing the parking lot and approached a parked car. Indicating, s/he was not receiving any supervision for a second time. <p>Further review revealed, the resident and his/her family member, who was in the parked car, made their way to and sat at a picnic table until 1:44 PM. They were then observed entering the facility together. The resident was observed wearing a belt.</p> <ul style="list-style-type: none"> - 2:20 PM- The Resident was observed being brought out of the facility to an ambulance. <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>During a follow-up surveyor interview on 9/12/2024 at approximately 10:45 AM with Staff C, after the surveyor had viewed the surveillance footage, Staff C acknowledged that the first time the resident was observed outside at approximately 10:40 AM she realized the resident was missing from the unit and asked a restorative aid to search for him/her. She revealed that the second time the resident was observed outside at approximately 12:28 PM, she was not aware of his/her whereabouts, indicating that the resident was not receiving any type of supervision both times s/he was able to leave the unit s/he resided on and the facility.</p> <p>During a surveyor interview with the DON on 9/10/2024 at 9:45 AM she revealed that she was not made aware of the events that occurred with Resident ID #1 on 9/7/2024 until approximately 10:00-10:30 AM, 7 hours after the incident had occurred. She indicated that she directed the staff to perform frequent checks until they sent the resident out to the hospital for a psychiatric evaluation. Furthermore, she revealed that she was initially unaware of the facility's Suicide Attempt or Threats policy and was unaware of the unsafe items that remained in the resident's room, prior to him/her being sent out to the hospital. Additionally, the DON acknowledged that the facility failed to place the resident on one-to-one supervision or assigning a staff member to stay with him/her on a one-to-one basis until s/he was sent to the emergency room, following his/her suicide attempt. Furthermore, the DON revealed that there was no documentation available to demonstrate that the facility had placed the resident on frequent checks for his/her safety.</p> <p>The facility's failures to ensure the resident received adequate supervision following an elopement attempt is evidenced by:</p> <ul style="list-style-type: none"> - the failure to follow their own Suicide Attempt or Threats policy and not placing the resident on one-to-one supervision or assigning a staff member to stay with the resident on a one-to-one basis until s/he was sent to the emergency room . - the failure to supervise the resident after s/he tried to hang him/herself, as s/he was left unsupervised in his/her room where multiple ligature risks were accessible to him/her. - the failure to monitor his/her whereabouts after making a suicide attempt, as s/he was observed being outside of the facility unsupervised twice that same day. <p>These failures had the potential to place the resident at risk for more than minimal harm, death, or impairment.</p> <p>Cross reference F600</p>		