

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415099	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/13/2024
NAME OF PROVIDER OR SUPPLIER  Crystal Lake Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  999 South Main Street Pascoag, RI 02859	

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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50004</b></p> <p>Based on record review, witness, resident, and staff interviews, it has been determined that the facility failed to ensure that residents receive adequate supervision to prevent an accident for 1 of 3 residents reviewed for elopement, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Record review of a 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 .Procedure .The Licensed Nurse will conduct an Elopement Risk Screen on admission, quarterly, and upon change of condition .A care plan will be developed and implemented .The Licensed Nurse will have visual contact with each resident .and/or know where each resident is .</p> <p>Record review of a facility policy titled Wandering Management System states in part .A wander management is system is used for residents/patients at risk for elopement as assessed and determined by the interdisciplinary team .The wander management system bracelet will be applied to the resident's wrist or ankle and not removed until replacement is needed .</p> <p>Surveyor observation on 6/13/2024 at approximately 9:00 AM revealed the facility is equipped with a wander guard system. When a resident wearing bracelet attempts to leave the facility an alarm will go off alerting the staff.</p> <p>Record review revealed, the resident was readmitted to the facility in September of 2023 with diagnoses including, but not limited to, dementia, cognitive communication deficit and chronic obstructive pulmonary disease.</p> <p>Review of the Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 3 out of 15, indicating s/he has severely impaired cognition.</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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of an incomplete elopement assessment dated [DATE] revealed that the resident is at minimal risk for elopement and an elopement care plan is not needed at this time. Although, the elopement assessment indicated that an elopement care plan was not needed at this time, record review revealed a baseline care plan dated 9/29/2023 was initiated . The baseline care plan indicated that the resident was at risk for elopement with an intervention to Re-direct from elevator and doorways if resident is seeking to exit. Engage in diversional activities and reassure as needed. When resident begins to wander or become restless provide basic needs and comfort measures.</p> <p>Record review of a progress note dated 11/20/2023 states in part, .Observed outside on patio, near gate. Question the need of a Wander guard. Elopement observation filed.</p> <p>Record review failed to reveal evidence that the facility completed an investigation to determine how the resident was able to get outside on the patio near the gate. Additionally, the facility was unable to provide evidence that a wander guard was implemented after the incident on 11/20/2023 per the facility policy.</p> <p>Record review of a facility document titled Elopement Evaluation dated 11/20/2023 indicated in part . Resident is cognitively impaired, poor decision-making skills, and/or pertinent diagnosis .History of wandering (into unsafe areas) .Resident is at risk for elopement .Elopement care plan initiated .</p> <p>Record review of the care plan failed to reveal evidence it was updated or that any new interventions were implemented following the incident on 11/20/2023.</p> <p>Further record review failed to reveal evidence that quarterly elopement evaluations were completed in February and May 2024, per the facility policy.</p> <p>Review of a facility reported incident sent to the Rhode Island Department of Health on 6/11/2024 revealed that on 6/9/2024 Resident ID #1 was observed in the road by a person in the community who called the neighboring facility.</p> <p>Record review of facility investigation statements for the 6/9/2024 incident indicate, staff recall seeing the resident between 9:00 AM and 9:30 AM, during morning care, but no one witnessed the resident exit the facility.</p> <p>During a surveyor interview on 6/11/2024 at 10:35 AM, with the witness who works at a neighboring facility, she revealed that she received a phone call of concern at approximately 9:00 AM on 6/9/2024 from an unknown caller. The caller indicated that an older person in a wheelchair was on the main road. When the witness arrived at the road, she noted Resident ID #1 was struggling to self-propel in the lane of traffic with several cars going around him/her. S/he had oxygen on, but the nasal cannula was on his/her forehead. The resident was not wearing shoes only slipper socks. The resident indicated that s/he resided at Crystal Lake and agreed to return with her. She assisted the resident back to Crystal Lake by pushing him/her in the wheelchair and spoke to the nurse on duty to report the incident. She further indicated the nurse was unaware that the resident had eloped from the facility.</p> <p>(continued on next page)</p>		

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