2019

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity

Apple Rehab Rocky Hill
45 Elm St.
Rocky Hill, CT 06067
M:

FLIS Staff

Anita Nicolla

Licensure Category:

CCNH

Licensed Bed Bassinet Capacity: 120

Census: 88

Date(s) of onsite inspection: 3/16/20

Date(s) additional information obtained: _____

Personnel contacted: Melissa Cope - Acting DON, Cory Cheyne - Administrator

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

[ ] Licensing Inspection [ ] *Initial* [ ] *Renewal* [ ] *Other (e.g.strikes)*: _____

[ ] Visit **OR** Revisit for the purpose of _____

[✓] See Complaint Investigation # 27098

[✓] Violations of the General Statutes of Connecticut and/or regulations of Connecticut State Agencies were identified at the time of this inspection. See attached violation letter dated 7/10/20

[ ] Desk Audit _____ [ ] Amended Letter: _____ Original Ltr. _____

[ ] Citation # _____ was issued to this facility as a result of this inspection.

[ ] Violations of the General Statutes of Connecticut and/or the regulations of Connecticut State Agencies **were not** identified at the time of this inspection.

[ ] Citation # _____ was/was not verified as corrected. See attached narrative report.

[ ] Narrative report/additional information attached.

[ ] See Certification File.

[ ] Referral(s) to _____

REPORT SUBMITTED BY: Anita Nicolla **DATE OF REPORT:** 3/18/20

[ ] Approval for issuance of license granted by: _____ **DATE:** _____
Supervisor/Title

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Renée D. Coleman-Mitchell, MPH
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

IMPORTANT NOTICE - PLEASE READ CAREFULLY

July 10, 2020

Cory Cheyne, Administrator
Apple Rehab Rocky Hill
45 Elm Street
Rocky Hill, CT 06067

Dear Mr. Cheyne:

An unannounced visit was made to Apple Rehab Rocky Hill on March 16, 2020 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which was noted during the course of the visits. The state violations cannot be edited by the provider in any way.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction through the ePOC website to the Department in response to the items of noncompliance identified in such notice.

The plan of correction is to be submitted to the Department by July 20, 2020.

The plan of correction shall include:

(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;

(2) the date each such corrective measure or change by the institution is effective;

(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and

(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by AJuly 20, 2020 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

We do not anticipate making any practitioner referrals at this time.

Please return your response to the Supervising Nurse Consultant through the ePOC(as an attachment) website and direct your questions regarding the violations and any questions concerning the instructions contained in this letter to the Supervising Nurse Consultant at (860) 509-7400. Please do not send another copy via US mail.

Respectfully,

Karen Gworek, RN

Karen Gworek, RN
Supervising Nurse Consultant
Facility Licensing and Investigations Section

KEG:mb

Complaint #27098

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2)(A) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A).

1. Based on clinical record reviews, review of facility documentation and interviews for one of three sampled residents (Resident #1) who were reviewed for behaviors, the facility failed to update the psychiatrist when Resident #1 behaviors continued to escalate, and the resident exhibited new behaviors. The findings include:
   a. Resident #1's diagnoses included Alzheimer's disease, and major depressive disorder. The quarterly Minimum Data Set assessment dated 11/7/19 identified Resident #1 rarely or never made decisions regarding tasks of daily life, impaired cognition, rejected care one (1) to three (3) days in a week, was independent with transferring in and out of the bed, ambulating in room, corridor, and on and off the unit, and dressing, required one (1) person extensive assistance with personal hygiene and toileting, was occasionally incontinent of urine, had no falls in the past ninety (90) days and received antidepressant, anticoagulant and diuretic medications. The Resident Care Plan dated 11/14/19 identified Resident #1 had a problematic manner characterized by ineffective coping and a paranoid and suspicious behavior related to the dementia. Resident #1 often attempted to barricade the room door with a chair because Resident #1 believed a stranger would come into his/her room. Interventions directed to be careful not to invade the resident's personal space, to announce that you were the "nurse" prior to coming into the room when the door was closed, identify the causes and reassure, establish daily routine with resident, and explain all procedures. The social service note dared 1/10/20 at 2:19 PM identified Resident #1 and the resident's family were made aware of a room change to occur on 1/13/20, no concerns were voiced, and the social worker would remain involved as needed. The nurse's note dated 1/13/20 at 3:37 PM identified Resident #1 was not receptive to a new roommate and kept closing the door. The note indicated the staff would open the door each time Resident #1 closed it. Review of the nurse's notes from 1/14/20 through 1/15/20 identified Resident #1 continued to close the door and barricade the door with a table and chair. The nurse's note dated 1/16/20 at 2:41 PM identified that Resident #1 continued to be resistive to care and closing the door and the resident used the door to hit a care giver when the caregiver tried to enter the room. The psychiatry progress note dated 1/16/20 identified the staff requested Resident #1 be seen by psych due to hygiene and non-compliance. The progress note identified the plan was a change in the medication regimen and to monitor for effectiveness or change in behavior. An Advanced Practice Registered Nurse's order dated 1/16/20 directed to increase the 6:00 AM dose of Trazadone to 75 milligrams (mg), continue the Trazadone 50mg at 2:00 PM and 10:00 PM, and follow up with psychiatry if Resident #1 was not allowing care and showers. Review of the nurse's notes from 1/17/20 through 1/28/20 identified Resident #1 continued to close the door and was not easily redirected at times, became agitated and physically combative towards staff whenever the door was re-opened, Resident #1 tried to hit a nurse aide with the door and a plastic shoehorn, Resident #1 struck out with the reacher and propped the door closed with the bedside table and a chair. The psychiatry progress note dated 1/29/20 identified Resident #1 was seen due to increased agitation, restlessness, anxiety and combativeness. The plan was to discontinue the Lexapro due to question of Selective Serotonin Reuptake Inhibitors (SSRI) induced agitation. Review of the nurse's notes from 1/30/20 through 2/22/20 identified Resident #1 continued to close the door to the

room and with redirection Resident #1 began to swear and yell. The notes identified Resident #1 was soaking wet with urine and it took two (2) nurse aides to get Resident #1 to cleaned up, Resident #1 continued to be combative, voided on the floor and self, Resident #1 took roommate's nightstand and put it in front of the door, Resident #1 continued to scream and yell about closing the door and turned the heat up, Resident #1 was cursing and shaking a fist at a nurse aide. The nurse's note dated 2/22/20 at 2:32 PM identified Resident #1 had approached the roommate with a fist raised, was verbalizing foul language and the roommate was moved to another room. The nurse note dated 2/25/20 at 4:34 PM identified that the empty bed was removed without difficulty. Resident #1 continued to be monitored every thirty (30) minutes. Review of the clinical record from 130/20 through 2/25/20 failed to reflect documentation that psychiatry had been notified when Resident #1 behaviors continued to escalate, and the resident exhibited new behaviors. The psychiatrist's progress note dated 2/25/20 identified Resident #1 was seen for agitated dementia and barricading self in the room. The note identified Resident #1 smelled of urine and feces and Resident #1 would be transferred to the hospital in the morning. The psychiatrist's progress note dated 2/26/20 identified Resident #1 was seen in follow up, Resident #1 remained gravely disabled, and was unsafe to remain at the long term care facility, and with no direct admit bed available at the Geri psych hospital, Resident #1 will be sent to the Emergency Department on a Physician's Emergency Certificate (PEC). The nurse's note dated 2/26/20 at 1:21 PM identified Resident #1 was transferred to the Emergency Department at an acute care hospital. Interview with a psychiatrist, MD #1, on 3/16/20 at 2:45 PM identified that he assessed Resident #1 on 1/29/20. MD #1 indicated that if Resident #1 was not responding to redirection, the facility staff should not have waited, the psychiatrist should have been notified within the same day or Resident #1 should have been send to the hospital if he/she was not responding to mediation changes. Interview and clinical record review with the acting Director of Nursing (DON) on 3/16/20 at 3:30 PM identified that there should have been some type of a plan developed by the interdisciplinary team to address Resident #1's behaviors and develop a coping mechanism.

Plan of Correction for Violation #1:

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (s) Social Work (7).

2. Based on clinical record reviews, review of facility documentation, policy review, and interviews for one of three sampled residents (Resident #1) who were reviewed for behaviors, the facility failed to ensure psychosocial support was provided to the resident after receiving a new roommate. The findings include:

a. Resident #1's diagnoses included Alzheimer's disease, and major depressive disorder. The quarterly Minimum Data Set assessment dated 11/7/19 identified Resident #1 rarely or never made decisions regarding tasks of daily life, impaired cognition, rejected care one (1) to three (3) days in a week, was independent with transferring in and out of the bed, ambulating in room, corridor, and on and off the unit, and dressing, required one (1) person extensive assistance with personal hygiene and toileting, was occasionally incontinent of urine, had no falls in the past ninety (90) days and received antidepressant, anticoagulant and diuretic medications. The Resident Care Plan dated 11/14/19 identified Resident #1 had a problematic manner characterized by ineffective coping and a paranoid and suspicious behavior related to the dementia. Resident #1 often attempted to barricade the room door with a chair because Resident #1 believed a stranger would come into his/her room. Interventions directed to be careful not to invade the resident's personal space, to announce that you were the "nurse" prior to coming into the room when the door was closed, identify the causes and reassure, establish daily routine with resident, and explain all procedures. The social service note dared 1/10/20 at 2:19 PM identified Resident #1 and the resident's family were made aware of a room change to occur on 1/13/20, no concerns were voiced, and the social worker would remain involved as needed. The nurse's note dated 1/13/20 at 3:37 PM identified Resident #1 was not receptive to a new roommate and kept closing the door. The note indicated the staff would open the door each time Resident #1 closed it. Review of the clinical record failed to identify Resident #1 was provided a psychosocial support when Resident #1 was not receptive to a new roommate and exhibited new behaviors. Interview with Social Worker #1 on 3/16/20 at 3:03 PM identified that if he addressed Resident #1's adjustment to the new room and roommate he would have documented in the clinical record. Interview and clinical record review with acting Director of Nursing (DON) on 3/16/20 at 3:30 PM identified that the expectation was for the social worker to follow up with the resident regarding Resident #1's adjustment to new roommate, address behaviors and coping mechanism. The room transfer and roommate change policy identified that documentation of a room transfers, a change in roommates, and follow-up note would be documented in the resident record. Any concerns will be addressed accordingly and documented in the resident's record.

Plan of Correction for Violation #2:

ROCKY HILL 3/16/20 COMPLAINT SURVEY

Approved 7/17/20 KEG

F 740 BEHAVIORAL HEALTH

1. Resident # 1 is followed by psychiatry. Psychiatry is updated and the resident is seen when her behaviors escalate and/or exhibits new behaviors.
2. All residents have the potential to be affected by this practice. The facility ensures that psychiatry is updated and resident is seen by psychiatry when there are escalated behaviors and/or exhibits new behaviors.
3. Licensed nursing staff will be educated that psychiatry needs to updated and resident needs to be seen by psychiatry when there are escalated behaviors and/or resident exhibits new behaviors.
4. The DNS or designee will conduct weekly random audits of residents with behaviors to ensure psychiatry is updated and the resident is seen by psychiatry when resident has escalated behaviors and/or exhibits new behaviors. Audits will be reviewed for compliance and QA as needed for concerns.
5. Substantial compliance by August 3, 2020

F 745 Medically Social Services

1. Resident # 1 no longer has a roommate at this time.
2. All residents have the potential to be affected by this practice. The facility ensures that the social worker provides psychosocial support to a resident after receiving a new roommate.
3. The social worker will be educated that when a resident receives a new roommate that psychosocial support needs to be provided and documented in the resident's record.
4. The DNS or designee will conduct weekly random audit of a resident that has received a new roommate to ensure psychosocial support was provided by the social worker and documented in the resident's record. Audits will be reviewed for compliance and QA as needed for concerns.
5. Substantial compliance by August 3, 2020.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

LICENSING INSPECTION REPORT

D/B/A Name and Address of Entity | ***Signature of Survey Staff***

Apple Rocky Hill
45 Elm St.
Rocky Hill, CT 06067

Licensure Category: CCNH

Licensed Bed/Bassinet Capacity: 120

Census: 85

Date(s) of onsite inspection: 11/14/19 + 11/18/19 11/19/19

Date(s) additional information obtained: _____

Personnel contacted: Cory Cheyne - Facility Administrator

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

[ ] Licensing Inspection [ ] *Initial* [ ] *Renewal* [ ] *Other*: (e.g. Strike) _____

[ ] Visit **OR** Revisit for the purpose of _____

[ ] See Complaint Investigation # CT 26467 + CT 26297

[X] Violations of the General Statutes of Connecticut and/or regulations of Connecticut State Agencies **were** identified at the time of this inspection. 12/2/19

[ ] Desk Audit _____ [ ] Amended Letter date: _____

[ ] Citation # 2019-57 was issued to this facility as a result of this inspection.

[ ] Violations of the General Statutes of Connecticut and/or the regulations of Connecticut State Agencies **were not** identified at the time of this inspection.

[ ] Citation # _____ was/was not verified as corrected. See attached narrative report.

[ ] Narrative report/additional information attached.

[X] See Certification File.

[ ] Referred to: _____.

REPORT SUBMITTED BY: _____ **DATE OF REPORT:** 11/21/19

[ ] Approval for issuance of license granted by: _____ **DATE:** _____
Supervisor/Title

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Renée D. Coleman-Mitchell, MPH
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

IMPORTANT NOTICE - PLEASE READ CAREFULLY

December 2, 2019

Cory Cheyne, Administrator
Apple Rehab Rocky Hill
45 Elm Street
Rocky Hill, CT 06067

Dear Mr. Cheyne:

Unannounced visits were made to Apple Rehab Rocky Hill which concluded on November 19, 2019 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations.

Violations of the Connecticut General Statute and/or Regulations of Connecticut State Agencies are attached to the ePOC website for your facility.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction through the ePOC website to the Department in response to the items of noncompliance identified in such notice.

The plan of correction is to be submitted to the Department by December 12, 2019.

The plan of correction shall include:

(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;

(2) the date each such corrective measure or change by the institution is effective;

(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and

(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by December 12, 2019 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

We do not anticipate making any practitioner referrals at this time.

Please return your response to the Supervising Nurse Consultant through the ePOC (as an attachment) website and direct your questions regarding the deficiencies and any questions concerning the instructions contained in this letter to the Supervising Nurse Consultant at (860) 509-7400. Please do not send another copy via US mail.

Respectfully,

Susan Newton, RN, BS
Supervising Nurse Consultant
Facility Licensing and Investigations Section

SHN:mb

Complaint #26467, 26297

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(C).

1. Based on clinical record review, facility documentation, interviews and policy review, for two of six residents who were at risk for elopement (Resident #1 and Resident #2), the facility failed to ensure that the resident had every fifteen minute checks completed in accordance with facility policy after an elopement and failed to ensure that a wander guard device was monitored in accordance with facility policy. The findings include:
   a. Resident #1 was admitted to the facility on 8/14/19 with diagnoses that included vascular dementia with behavioral disturbances, hallucinations and agitation.
   An elopement assessment dated 8/15/19 identified that that the resident was at risk for elopement because of independent mobility, a history of elopement and repetitive requests to leave the facility.
   An admission care plan dated 8/15/19 identified that the resident frequently wandered and was at risk for elopement from the building with interventions that included a wander guard device, and if seen near an exit door, offer to escort the resident to another area of the building.
   An admission Minimum Data Set (MDS) dated 8/21/19 identified that the resident had severely impaired cognition, needed supervision with Activities of Daily Living (ADL's), was independent with ambulation, and wandered one to three days which put the resident at significant risk for wandering into dangerous places.
   Review of the nurse's notes from 8/15/19 to 10/12/19 identified wandering behaviors with exit seeking behavior noted on 8/22, 8/28, and 9/15/19.
   Review of nurse's notes dated 10/14/19 identified that it was a late entry for 10/12/19. The resident returned to the facility alert, cooperative, with no noticeable signs of injury, the police were notified and the entry and exit doors to the dementia unit were disarmed and would not be used by staff to enter and exit the unit.
   Review of a reportable event and investigation dated 10/12/19 at 10:30 AM identified that the resident ran out of the building behind a staff member, Licensed Practical Nurse (LPN) #2, and the staff member did not realize that the resident was behind her. The resident was observed by a staff member, and when the staff attempted to stop the resident, h/she started to run and crossed a highway, the staff followed until the resident could be redirected. The resident was placed on every fifteen minute checks and will be seen by psychiatric services.
   Review of every 15 minute check sheets identified that they were initiated on 10/12/19 at 12:00 PM. Further review identified that on 10/14/19 the every fifteen minute checks were left blank from 2:15 PM until 11:00 PM. The checks then continue until 10/15/19 at 3:00 PM.
   Review of a psychiatric evaluation dated 10/15/19 identified that the resident had left the facility and was currently not a danger to self or others.
   Interview with the Director of Nurses (DON) on 11/19/19 at 1:45 PM identified that the every fifteen minute checks were initiated as a nursing measure after the elopement, and continued until psychiatric services evaluated the resident to not be a risk to his/herself on 10/15/19, then they were discontinued. The DON identified that the sheets lacked every fifteen minute checks on 10/14/19 from 2:15 PM until 11:00 PM.

Review of the policy for close monitoring of a resident and every fifteen minute checks identified that the 15 minute checks must continue until they are discontinued.

b. Resident #2 was admitted on 8/26/19 and had diagnoses that included vascular dementia with behavioral disturbance and a generalized anxiety disorder.
An admission assessment dated 8/26/19 identified that the resident was confused and required assistance with ADL's.
An elopement risk assessment dated 8/26/19 identified that the resident was at risk for elopement due ability to ambulate independently, repetitively expressing the desire to leave the facility and exit seeking.
Review of physician's order's dated 8/26/19 directed to have a wander guard for safety.
Review of physician's orders dated 8/27/19 directed to have the wander guard, check function every day on the 11:00 PM to 7:00 AM shift and to check placement every shift.
A care plan dated 8/27/19 identified that the resident was at risk for elopement due to frequent wandering with interventions that included to apply a wander guard and to check placement and function per policy, and to redirect if seen heading to an exit door.
Review of the August 2019 and September 2019 Treatment Administration Record (TAR) identified that the August 2019 TAR identified that the wander guard was entered onto the TAR as wanderguard for safety, and was checked every shift on 8/26, 8/27, and on the 7:00 AM to 3:00 PM shift on 8/28/19, but lacked any documentation that the wander guard was checked for the remainder of 8/28, and all shifts on 8/29, 8/30, and 8/31/19. The September 2019 TAR lacked any documentation regarding the wander guard until 9/5/19, when it was entered onto the TAR to check placement to the right hand every shift, and to check the function every night on the 11:00 PM to 7:00 AM shift. Although the check placement every shift was documented starting on 9/5/19 there was no documentation that the wander guard was checked for placement every shift from 8/29 - 9/5/19, (a total of 8 days) and there was no documentation the entire month of September that the function was checked every day on the 11:00 PM to 7:00 AM shift.
Interview with the DON on 11/19/19 at 1:45 PM identified that when a wander guard is placed on a resident the order must include to check wander guard placement every shift, and to check function every day on the 11:00 PM to 7:00 AM shift. The documentation lacked wander guard checks from 8/29/18 through 9/5/19 and function tests for the entire month of September 2019.
Review of the elopement risk policy identified that the elopement bracelets will be checked daily, and at the beginning of each shift the placement of the wander guard will be checked and both will be documented in the TAR.

Plan of Correction for Violation #1:

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(C).

2. Based on clinical record review, facility documentation, policy review and interviews, for three of six residents (Resident #1, #2, and #3) who were at risk for elopement, the facility failed to ensure that a resident who was on a secured dementia unit did not exit the unit and facility unattended, that the exit doors were checked daily for function, and that the facility instituted appropriate interventions after exit seeking behavior was identified to prevent multiple resident elopements. The findings include:
   a. Resident #1 was admitted to the facility on 8/14/19 with diagnoses that included vascular dementia with behavioral disturbances, hallucinations and agitation.
   A care plan dated 8/15/19 identified that the resident frequently wandered, and was at risk for elopement from the building with interventions that included a wander guard device, and if seen near an exit door, offer to escort the resident another area of the building.
   An elopement assessment dated 8/15/19 identified that that the resident was at risk for elopement because of independent mobility, a history of elopement, and repetitive requests to leave the facility.
   An admission Minimum Data Set (MDS) dated 8/21/19 identified that the resident had severely impaired cognition, needed supervision with Activities of Daily Living, was independent with ambulation, and wandered one to three days, which put the resident at significant risk for wandering into dangerous places.
   Review of the nurse's notes from 8/15/19 to 10/12/19 identified wandering behaviors with exit seeking behavior noted on 8/22, 8/28, and 9/15/19.
   Review of nurse's notes dated 10/14/19 identified that it was a late entry for 10/12/19. The resident returned to the facility alert, cooperative, with no noticeable signs of injury, the police were notified and the entry and exit doors to the dementia unit were disarmed and would not be used by staff to enter and exit the unit.
   Review of a reportable event and investigation dated 10/12/19 at 10:30 AM identified that the resident ran out of the building behind a staff member Licensed Practical Nurse (LPN) #2, and the staff member did not realize that the resident was behind her. The resident was observed by a staff member, and when the staff attempted to stop the resident, h/she started to run, and crossed a highway, the staff followed until the resident could be redirected.
   Interview and observation with the DON, administrator, and Housekeeping Aide (HA) #1 on 11/18/19 at 9:30 AM at the location of where the resident crossed the highway identified a four way intersection, with four lanes, and a high traffic pattern.
   Observation and interview with the Director of Nursing (DON), Administrator, and the Director of Maintenance (DOM) on 11/18/19 at 10:00 AM identified that the locked dementia unit has 2 exit doors leading to the back parking lot. One door is a fire door and is only accessed in an emergency. The other door leads to the back parking lot, which is the door that Resident #1 exited through, and it is not wander guard equipped. The door has an alarmed delayed egress of 15 seconds. When the door is pushed an alarm sounds and after 15 seconds it will open, the door will alarm until a code is entered into the keypad. The DOM stated that the door can be opened by entering a code into the keypad, which allowed staff to enter and exit the unit from the back parking lot. The DOM further stated that up

until Resident #1 had exited this door on 10/12/19, it was the main entrance and exit for staff that worked on the locked dementia unit.
Interview with NA #2 on 11/19/19 at 1:05 PM identified that she had last seen the resident walking in the hallway around 9:30 AM.
Interview with LPN #2 on 11/19/19 at 10:06 AM identified that on 10/12/19 another resident had fallen, and when she determined that the resident had no injuries, she then went to her car to retrieve a stethoscope (although there was a stethoscope available on the unit). She exited the locked dementia unit by entering the code into the keypad which disarmed the door, and ran to her car to get the stethoscope. She identified that she did not see Resident #1 in the hallway at her time of exit, and although she did turn around to see if any resident had followed her out, she did not ensure that the door had completely closed, although she had been trained to do so.
Interview with the Administrator on 11/19/19 at 9:00 AM identified that the video of the incident was no longer available for review because the camera "loops", and it had been erased. He further identified that he had watched the video footage of the resident's exit on 10/12/19 and had determined that when LPN #2 exited the unit into the back parking lot, she did not look back and/or ensure the door was closed prior to turning her back and continuing to her car. After LPN #2 exited the door, the resident was seen exiting the door right before it closed entirely. The administrator further identified that any time a staff member exits the locked dementia unit they should ensure a resident has not followed them, and furthermore ensure the door is completely shut before turning their back and heading to the parking lot.
Interview with Nurse Aide #1 on 11/18/19 at 10:00 AM identified that she was providing care to another resident and saw a person in the parking lot through the window, and was not sure if the person was a resident, but thought h/she looked familiar. She stopped what she was doing and went outside where she saw Housekeeping Aide (HA) #1 in the parking lot, and stated that she did not know the resident's name but though it was a resident from downstairs (the locked dementia unit). HA#1 started to follow the resident, while she (NA #1) went to the dementia unit to inform the staff that a resident is outside, with HA#1 following the resident. The staff did a head count and determined it was Resident #1. NA#1 stated that she did not follow the resident, because she thought that HA#1 could "control" the resident better.
Interview with HA#1 on 11/18/19 at 9:30 AM identified that he was in the dining room washing the floor when he looked outside and saw who he thought to be a resident, but was unsure of the resident's name. He ran out of the building and attempted to get the resident back in to the building, but was unsuccessful, the resident was scratching and trying to kick him, so he followed the resident as he/she proceeded out of the facility driveway, and onto the sidewalk. When he got to the end of the driveway he called the facility to inform them that he was following the resident, and had asked a bystander to call 911. HA#1 identified that he followed the resident down the street. The resident started to run, and ran through a four way intersection of a four lane highway, and then tried to enter a church (which was locked), and ended up by the town hall (0.2 miles from the facility), the police and Registered Nurse #1 responded at that time and the resident was taken back to the facility.
Further interview with LPN #2 on 11/18/19 at 2:00 PM identified that as soon as it was identified that it was Resident #1 that had left the building she went outside to search the area around the facility along with NA #3. They did not know where the resident was

located, only that HA#1 was following the resident.
Interview with Registered Nurse (RN) #1 on 11/18/19 at 2:25 PM identified that she was the nursing supervisor on 10/12/19 when the resident eloped. She identified that she was notified by NA #1 that a resident was outside. They checked the unit and determined that it was Resident #1 who was outside. She came upstairs and went outside, and looked up and down the street, but did not see the Resident #1 or HA#1. She went back into the building and received a phone call from HA #1 that stated that he was following Resident #1 and made mention that someone had already called 911. She stated she can't recall exactly what she did when she came back into the building, but she thought that she may have called the police department for an update. A few minutes later the HA #1 called her and stated that the police had arrived, and Resident #1 was resisting when asked to return to the building, so she had gone to pick up the resident who returned to the facility. An assessment identified no injuries. RN #3 further identified that there was no "Dr. Hunt" called when the resident exited the building and 911 was not called by the facility because they knew the resident was with HA#1. RN #3 stated that she was not aware that LPN #2 and NA #3 went out to search for Resident #1.
Interview with the DON on 11/19/19 at 9:45 AM identified that the she was not notified on 9/22/19 that the Resident #1 had attempted to climb through a window, and would expect the nursing staff to put an intervention into place for the exit seeking behavior, but was unable identify that an intervention was initiated. She further identified that Resident #1 was last seen at 9:30 AM on 10/12/19, LPN #2 had gone to her car at approximately 9:50 AM, and the resident had exited the building shortly after, through the locked key padded door that was accessed by LPN #2. The resident returned to the building at approximately 10:30 AM. The DON identified that LPN #2 should have turned to check if there was a resident behind her and ensure the door was completely shut before turning her back to the door. The DON further identified that a "Dr. Hunt" and/or the facility calling 911 was not necessary because the facility knew that the resident was with HA#1, although the DON identified if a Dr. Hunt was called they would have had more staff members searching for the resident. The DON stated that after Resident #1 left through the door on 10/12/19, the keypads were immediately disabled, and all staff were told they could not use that door to enter and/or exit the unit, and a wanderguard audit was done on 10/14/19. The resident was also placed on every 15 minute checks until cleared by psychiatric services on 10/15/19. The DON stated that education about staff looking behind to ensure a resident had not exited the door behind them, and that the door is completely closed was not done because there are signs on the door to remind visitors to ensure they only leave with the party they entered with. The facility had educated staff starting on 11/6/19 about checking behind and making sure the door locks behind them because with the inclement weather coming, they will be re-opening the doors for staff entry/exit.
Interview with Corporate Nurse (CN) #1 on 11/19/19 at 1:30 PM identified that the facility had not done an elopement drill since at least January 2018, and she was unsure of the reason. CN #1 further identified that she felt it was appropriate to have HA#1 follow the resident instead of NA#1 because all staff has dementia training.
The facility stated that they did not have a specific policy that addresses staff checking to ensure a resident has not followed them out, and ensuring that the door is completely closed while exiting the locked dementia unit, but all staff are trained to do so.

The facility failed to ensure a staff member that exited the building from the locked dementia unit was not followed by a resident who was at risk for elopement and had exit seeking behavior.

b. Resident # 3 had diagnoses that included dementia, anxiety, and depression.
A care plan dated 2/4/19 identified that the resident wandered often, with interventions that included a wander guard device to the left ankle.
A quarterly MDS dated 8/8/19 identified that the resident had moderate cognitive impairment, required extensive assistance with ADL's, and was independent with ambulation.
An elopement assessment dated 10/31/19 identified that the resident was at risk for elopement because of a previous history of elopement attempts, repetitively expressing desire to leave the facility, and exit seeking behavior.
Review of a physician's order dated 11/1/19 directed to have a wander guard to the left ankle and to check for placement every shift and check function daily on the 11:00 PM to 7:00 AM shift.
Review of the November 2019 Treatment Administration Record (TAR) identified that the wander guard was on the left ankle and was being checked for placement every shift, and was checked for function every night on 11:00 PM to 7:00 AM shift, in accordance with physicians orders.
Review of a nurse's note dated 11/15/19 at 7:32 AM identified that the resident was brought back to the unit by the supervisor after being found outside, wandering around the dumpster. The resident was wearing the wanderguard, but the alarm did not go off and/or the door did not lock. When the resident returned to the unit, the wander guard was tested and the alarm went off and the door locked.
Review of a reportable event dated 11/15/19 identified that the resident was noted outside the building by a facility vendor at 6:20 AM.
Review of timestamped camera footage (not equipped with sound) of the front door exit to the facility on 11/18/19 at 11:50 AM with the Administrator, and the DON identified that on 11/15/19 at 6:15:07 AM Resident #3 is approaching the front door, and at 6:16:00 AM, h/she starts to push on the door, and at 6:16:19 AM the door opens and the resident walks out the door and to the left, into the facility parking lot. At 6:17:49 NA# 4 is seen entering a code into the keypad, she then opens the door slightly, then closes the door, and then heads to the right and then is out of camera range. At 6:30:12 AM staff members are seen bringing the resident to the front door testing the wanderguard.
Review of the front door entrance to the facility with the DON on 11/18/19 at 1:30 PM identified that the front door is wander guard equipped and when a resident who is wearing a wander guard approaches the door the alarm will sound, and the door will lock for 15 seconds. If the door is pushed for 15 seconds, the door can be opened, with the alarm still sounding. The code must be entered into the keypad to silence the alarm. The DON further identified that the front door is unlocked allowing for staff entry at 6:00 AM, but this does not affect the wander guard system.
The temperature on 11/15/19 had a low of 26 degrees Fahrenheit, and sunrise was at 6:39 AM.
Interview with NA #4 on 11/19/19 at 7:06 AM identified that she was working on Resident #3's unit the morning of 11/15/19, and the unit is adjacent to the front door. She stated that

she had noticed while conversing with a resident in the lobby, that the light on the door alarm box was green (identifying that the door was unlocked), and she thought it should be red (identifying that the door was locked). She identified that when she was at the keypad, she was entering the code in an attempt to lock the door, because she thought it should be locked until 7:00 AM, but she was unable to lock the door using the keypad, and left because she figured that the staff would be entering the building for the first shift. NA#4 further identified that at no time was an alarm sounding, and when she was at the door alarm box, she was attempting to have the door lock, her actions had nothing to do with the wander guard alarm.

Interview with LPN#1 on 11/19/19 at 7:30 AM identified that he had checked Resident #3's wanderguard bracelet for function at the beginning of the 11:00 PM to 7:00 PM shift on 11/14 -11/15/19 and it was functioning appropriately. LPN #1 stated that he had last seen Resident #3 at 6:00 AM while administering medications. He identified that he was in the hallway from 6:00 AM until the resident was returned by the supervisor (around 6:30 AM) after being found outside. He stated that if the wander guard alarm sounds he can hear it in the hallway, and he did not hear any alarms sounding at any time during his shift.

Interview with NA #5 on 11/19/19 at 9:30 AM identified that she had seen Resident #3 around 4:00 AM on 11/15/19 AM on last rounds, and the resident was sleeping. NA#5 stated that although she can usually hear the front door alarm if it sounds, she did not hear the door alarm sound on that shift.

Interview with the Laundry Worker (LW) #1 on 11/19/19 at 12:15 PM identified that on 11/15/19 she was in the laundry room and the food delivery man came to the service door with Resident #1 and stated that he had found the resident in the parking lot. LW #1 identified that the resident was in his/her night clothes, but had a sweater on. She further identified that the resident was shivering and when she touched his/her hands they were cold. LW #1 stated that she took the resident to the nursing unit.

Interview with RN #2 (who is the 11:00 PM to 7:00 AM shift nursing supervisor) on 11/19/19 at 1:30 PM identified that on 11/15/19 LW#1 had brought the resident to her after h/she had been found outside, she noted that the resident's hands were cold. RN #2 completed an assessment, and no injuries were identified. She then took the resident to the front door and tested the wander guard and the alarm rang loudly, the door locked, and it was identified that the wander guard and door were functioning properly at that time.

Interview with the Service Manager (SM) at Secure Care (distributor that provides the wander guard system to the facility) on 11/19/19 at 2:35 PM identified that the only way to silence the wander guard alarm is to enter the code into the key pad. He further identified that if the front door was unlocked at the time the resident exited, and the door had locked for the 15 seconds before the resident was able to exit, it would appear that the wanderguard system was functioning. But if there was no sound on the video, you could not determine if the alarm had sounded. The SM further identified that it would be recommended to call the service company any time an issue with the wander guard system is identified.

Interview and review of the facility daily door checks with the Administrator and the DOM on 11/19/19 at 1:45 PM identified that he checks all doors for proper function every day, and checks the function of the wander guarded doors daily using the tester unit. Review of the daily door checks with the DOM identified that the door checks were not completed on 11/14/19 (the day prior to the elopement). The DOM identified that he was off on 11/14/19,

and his assistant would have usually completed the door checks in his absence but he was no longer employed at the facility. The Administrator identified that the doors were checked on 11/15/19 after the elopement by facility staff, and were functioning correctly, but they did not contact the service company to come to the facility and check the system. Review of the daily door checks from 7/2019 through 11/18/19 identified that the doors and/or wanderguard system were not checked on 53 days during that time period, and the DOM stated that he does not check the doors on the weekends and the days that he is off. The Administrator identified that he was unaware that the door/alarms were not being checked in the DOM's absence, and should be checked daily.
Subsequent to surveyor inquiry on 11/19/19 the administrator identified that housekeeping would now be in charge of checking the doors/alarms in the DOM's absence.
Interview with the DON on 11/19/19 at 2:00 PM identified that after the resident eloped the resident was taken to the front door and the resident's wander guard and the door was functioning properly, and the alarm sounded loudly. The DON further identified that it was unclear how the resident was allowed to exit the building through the wander guard secured door. The DON identified that although the facility was not sure how the resident was allowed to exit, the facility completed a wanderguard audit, and educated staff on responding to alarms when sounding, and on the elopement policy on 11/15/19.
Review of the elopement risk policy identified that the maintenance department is responsible for testing door alarms and keypads utilizing the tester unit, in the absence of the maintenance staff the Administrator will be responsible for ensuring a staff member in the facility is assigned to perform the testing of the door alarms and keypad utilizing the tester unit. The daily testing will be documented in the maintenance log.
The facility failed to ensure that the wander guard system was checked daily for functioning, and that a resident who was at risk for wandering and was wearing a wander guard device exited the building through a wander guard equipped door without staff knowledge on 11/15/19 at 6:00 AM.

c. Resident #2 was admitted to the facility on 8/26/19 and had diagnoses that included vascular dementia with behavioral disturbance and a generalized anxiety disorder.
An elopement risk assessment dated 8/26/19 identified that the resident was at risk for elopement due to repetitively expressing the desire to leave the facility and exit seeking.
A care plan dated 8/27/19 identified that the resident was at risk for elopement due to frequent wandering with interventions that included to apply a wander guard, check placement and function per policy, and to redirect if seen heading to an exit door.
An admission MDS dated 9/11/19 identified that the resident had severe cognitive impairment, required limited assist with ADL's, was independently ambulatory, and wandered daily which put the resident at significant risk for getting to a potentially dangerous place.
Review of a nurse's note dated 9/22/19 at 6:19 PM written by RN #3 (the nursing supervisor) identified that a NA who was on the oncoming shift informed her that Resident #2 was standing outside a window on the lower level. Upon arrival the resident was seen in the patio area outside the lounge window, the window was open with the screen seen on the patio. The resident was brought back inside and was noted to be limping and stated that h/she had fallen on his/her left knee when h/she climbed out of the window. Ice was applied and an x-ray ordered. Maintenance was notified and the window was secured.

A reportable event dated 9/22/19 identified that the resident had climbed out a window and fell onto his/her knee.
A nurse's note dated 9/23/19 identified that the x-ray to the left knee was negative.
Interview with NA # 6 on 11/19/19 at 9:00 AM identified that when she came to work on 9/22/19 around 2:45 PM she observed Resident # 2 outside on the patio. She immediately went to the resident and called the facility from her cell phone, and stayed with the resident until the staff arrived.
Interview with LPN #3 on 11/18/19 at 2:10 PM identified that she was Resident #2's regular charge nurse on the locked dementia unit. She stated that the day prior to the elopement (9/21/19) she was doing rounds sometime before 7:00 AM and when she entered Resident #2's room, the glass window was on the floor. It appeared that the resident had removed the window from the frame. LPN #3 stated that she had removed the glass window from the resident's room and reported it to the supervisor, and a short time later the DOM arrived and bolted the window shut. LPN #3 stated that on 9/22/19 she was in the hallway and another resident attempted to communicate with her, although unclear, it appeared she was trying to get her to go to the patio area. LPN #3 went to the lounge and saw NA #6 standing outside with Resident #2 outside on the patio. The resident was brought inside and an assessment was completed. A bruise was noted to the left knee, ice was applied and an x-ray was ordered.
Interview with RN #3 (nursing supervisor) on 11/19/19 at 12:05 PM identified that on 9/22/19 she received a call from staff that Resident #2 was outside the building on the patio. By the time she arrived LPN #3 was already inside with the resident. She stated that she called the DOM and he came in immediately and secured all of the windows on the dementia unit. RN #3 stated that she was not told that the resident had removed the window on 9/21/19, and she only heard about the incident in nursing report. She further stated that she did not notify maintenance of the event on 9/21/19.
Interview and observation with the DOM of Resident #2's window on 9/18/19 at 9:15 AM identified that on 9/21/19 he was informed by RN # 3 that the resident had removed the window from the frame, (although RN #3 stated that she was not aware of the incident). He came in soon after and bolted Resident #2's window shut with an "L" bracket and 2 screws. He further identified that the next day he received another call from RN #3 and was told the resident went through the lounge window. He explained that the resident was able to lift the window above the screw that was placed there to prevent the window from opening more than 6 inches, allowing him/her to exit the window. He came in that day and after a discussion with the Administrator decided to secure all of the windows on the unit.
Observation of windows on the secured unit identified that they are now completely secured and do not allow for the window to be opened at all.
Interview with the DON on 11/19/19 at 1:00 PM identified that she was not aware that the resident had removed the window on 9/21/19, and stated that although Resident #2's window was secured, all the other windows on the unit were not, and it would be possible for her to exit one of those windows, as she had her own. She stated that although she did not feel increased supervision for Resident #2 was necessary after removing the window on 9/21/19, she would likely have directed for all the windows on the unit to be secured to prevent the resident from going out another window.
Review of the elopement risk policy identified that all residents will have interventions

instituted.
The facility failed to ensure that a resident who had active exit seeking behavior had appropriate interventions in place to prevent an elopement.

Plan of Correction for Violation #2:

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3).

3. Based on facility documentation, interviews, and policy review, the facility failed to conduct daily door checks in accordance with facility policy. The findings include:
   a. Review of the daily door check documentation from 7/2019 until 11/18/19 identified that daily doors checks were not completed in accordance with facility policy. In July 2019 and August 2019 door checks were not completed on 11 days during each month. In September 2019 door checks were not completed on 13 days, in October 2019 door checks were not completed on 10 days, and up until November 18 2019 there were 8 days where the daily door checks were not completed.
   Interview with the Director of Maintenance (DOM) on 11/19/19 at 11:30 AM identified that the door checks include checking the keypads for function, checking the alarmed doors for function and ensuring that the wander guard system is functioning correctly. He further identified that he does not do the door checks on the weekends because he does not work the weekends, and he was not sure who checked the doors on his days off.
   Interview with the Administrator on 11/19/19 at 11:32 AM identified that the door checks should be completed daily, and he thought the nursing supervisor was checking the doors in the DOM's absence.
   Subsequent to surveyor inquiry on 11/19/19 the administrator identified that the housekeeping staff would be checking the doors in the DOM's absence.
   Review of the elopement risk policy identified that the Maintenance department is responsible for daily testing door alarms and keypads utilizing the tester unit, in the absence of the maintenance staff, the administrator is responsible for ensuring a staff member is assigned to perform door testing daily.

Plan of Correction for Violation #3:

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

POC Approved 12/5/19 STHN

Renée D. Coleman-Mitchell, MPH
Commissioner

Ned Lamont
Governor
Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

IMPORTANT NOTICE - PLEASE READ CAREFULLY

December 2, 2019

Cory Cheyne, Administrator
Apple Rehab Rocky Hill
45 Elm Street
Rocky Hill, CT 06067

Dear Mr. Cheyne:

Unannounced visits were made to Apple Rehab Rocky Hill which concluded on November 19, 2019 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations.

Violations of the Connecticut General Statute and/or Regulations of Connecticut State Agencies are attached to the ePOC website for your facility.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction through the ePOC website to the Department in response to the items of noncompliance identified in such notice.

The plan of correction is to be submitted to the Department by December 12, 2019.

The plan of correction shall include:

(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;

(2) the date each such corrective measure or change by the institution is effective;

(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and

(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by December 12, 2019 or if a request for a meeting is not made by the stipulated date, the violations shall be

deemed admitted.

We do not anticipate making any practitioner referrals at this time.

Please return your response to the Supervising Nurse Consultant through the ePOC (as an attachment) website and direct your questions regarding the deficiencies and any questions concerning the instructions contained in this letter to the Supervising Nurse Consultant at (860) 509-7400. Please do not send another copy via US mail.

Respectfully,

Susan Newton, RN, BS
Supervising Nurse Consultant
Facility Licensing and Investigations Section

SHN:mb

Complaint #26467, 26297

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(C).

1. Based on clinical record review, facility documentation, interviews and policy review, for two of six residents who were at risk for elopement (Resident #1 and Resident #2), the facility failed to ensure that the resident had every fifteen minute checks completed in accordance with facility policy after an elopement and failed to ensure that a wander guard device was monitored in accordance with facility policy. The findings include:
   a. Resident #1 was admitted to the facility on 8/14/19 with diagnoses that included vascular dementia with behavioral disturbances, hallucinations and agitation.
   An elopement assessment dated 8/15/19 identified that that the resident was at risk for elopement because of independent mobility, a history of elopement and repetitive requests to leave the facility.
   An admission care plan dated 8/15/19 identified that the resident frequently wandered and was at risk for elopement from the building with interventions that included a wander guard device, and if seen near an exit door, offer to escort the resident to another area of the building.
   An admission Minimum Data Set (MDS) dated 8/21/19 identified that the resident had severely impaired cognition, needed supervision with Activities of Daily Living (ADL's), was independent with ambulation, and wandered one to three days which put the resident at significant risk for wandering into dangerous places.
   Review of the nurse's notes from 8/15/19 to 10/12/19 identified wandering behaviors with exit seeking behavior noted on 8/22, 8/28, and 9/15/19.
   Review of nurse's notes dated 10/14/19 identified that it was a late entry for 10/12/19. The resident returned to the facility alert, cooperative, with no noticeable signs of injury, the police were notified and the entry and exit doors to the dementia unit were disarmed and would not be used by staff to enter and exit the unit.
   Review of a reportable event and investigation dated 10/12/19 at 10:30 AM identified that the resident ran out of the building behind a staff member, Licensed Practical Nurse (LPN) #2, and the staff member did not realize that the resident was behind her. The resident was observed by a staff member, and when the staff attempted to stop the resident, h/she started to run and crossed a highway, the staff followed until the resident could be redirected. The resident was placed on every fifteen minute checks and will be seen by psychiatric services.
   Review of every 15 minute check sheets identified that they were initiated on 10/12/19 at 12:00 PM. Further review identified that on 10/14/19 the every fifteen minute checks were left blank from 2:15 PM until 11:00 PM. The checks then continue until 10/15/19 at 3:00 PM.
   Review of a psychiatric evaluation dated 10/15/19 identified that the resident had left the facility and was currently not a danger to self or others.
   Interview with the Director of Nurses (DON) on 11/19/19 at 1:45 PM identified that the every fifteen minute checks were initiated as a nursing measure after the elopement, and continued until psychiatric services evaluated the resident to not be a risk to his/herself on 10/15/19, then they were discontinued. The DON identified that the sheets lacked every fifteen minute checks on 10/14/19 from 2:15 PM until 11:00 PM.
   Review of the policy for close monitoring of a resident and every fifteen minute checks identified that the 15 minute checks must continue until they are discontinued.
   b. Resident #2 was admitted on 8/26/19 and had diagnoses that included vascular dementia with behavioral disturbance and a generalized anxiety disorder.
   An admission assessment dated 8/26/19 identified that the resident was confused and

required assistance with ADL's.
An elopement risk assessment dated 8/26/19 identified that the resident was at risk for elopement due ability to ambulate independently, repetitively expressing the desire to leave the facility and exit seeking.
Review of physician's order's dated 8/26/19 directed to have a wander guard for safety.
Review of physician's orders dated 8/27/19 directed to have the wander guard, check function every day on the 11:00 PM to 7:00 AM shift and to check placement every shift.
A care plan dated 8/27/19 identified that the resident was at risk for elopement due to frequent wandering with interventions that included to apply a wander guard and to check placement and function per policy, and to redirect if seen heading to an exit door.
Review of the August 2019 and September 2019 Treatment Administration Record (TAR) identified that the August 2019 TAR identified that the wander guard was entered onto the TAR as wanderguard for safety, and was checked every shift on 8/26, 8/27, and on the 7:00 AM to 3:00 PM shift on 8/28/19, but lacked any documentation that the wander guard was checked for the remainder of 8/28, and all shifts on 8/29, 8/30, and 8/31/19. The September 2019 TAR lacked any documentation regarding the wander guard until 9/5/19, when it was entered onto the TAR to check placement to the right hand every shift, and to check the function every night on the 11:00 PM to 7:00 AM shift. Although the check placement every shift was documented starting on 9/5/19 there was no documentation that the wander guard was checked for placement every shift from 8/29 - 9/5/19, (a total of 8 days) and there was no documentation the entire month of September that the function was checked every day on the 11:00 PM to 7:00 AM shift.
Interview with the DON on 11/19/19 at 1:45 PM identified that when a wander guard is placed on a resident the order must include to check wander guard placement every shift, and to check function every day on the 11:00 PM to 7:00 AM shift. The documentation lacked wander guard checks from 8/29/18 through 9/5/19 and function tests for the entire month of September 2019.
Review of the elopement risk policy identified that the elopement bracelets will be checked daily, and at the beginning of each shift the placement of the wander guard will be checked and both will be documented in the TAR.

Plan of Correction for Violation #1:

1. **The facility ensures that if a resident has q 15 minute checks in place for elopement they are completed per facility policy. The facility ensures all residents with wander guards in place they are checked for placement and function per facility policy. Nursing staff will be educated on q 15 minute checks policy. Licensed nursing staff will be educated on the facility policy for wander guards.**
2. **12/31/19**
3. **DNS or designee will perform weekly audits on all residents on q shift 15 minute checks for elopement purposes to ensure they are completed. The DNS or designee will perform weekly audit of residents with wander guards in place to ensure placement and function are checked in accordance with facility policy. Audits will be reviewed and QA as needed.**
4. **Administrator or Designee**

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(C).

1. Based on clinical record review, facility documentation, policy review and interviews, for three of six residents (Resident #1, #2, and #3) who were at risk for elopement, the facility failed to ensure that a resident who was on a secured dementia unit did not exit the unit and facility unattended, that the exit doors were checked daily for function, and that the facility instituted appropriate interventions after exit seeking behavior was identified to prevent multiple resident elopements. The findings include:
   a. Resident #1 was admitted to the facility on 8/14/19 with diagnoses that included vascular dementia with behavioral disturbances, hallucinations and agitation.
   A care plan dated 8/15/19 identified that the resident frequently wandered, and was at risk for elopement from the building with interventions that included a wander guard device, and if seen near an exit door, offer to escort the resident another area of the building.
   An elopement assessment dated 8/15/19 identified that that the resident was at risk for elopement because of independent mobility, a history of elopement, and repetitive requests to leave the facility.
   An admission Minimum Data Set (MDS) dated 8/21/19 identified that the resident had severely impaired cognition, needed supervision with Activities of Daily Living, was independent with ambulation, and wandered one to three days, which put the resident at significant risk for wandering into dangerous places.
   Review of the nurse's notes from 8/15/19 to 10/12/19 identified wandering behaviors with exit seeking behavior noted on 8/22, 8/28, and 9/15/19.
   Review of nurse's notes dated 10/14/19 identified that it was a late entry for 10/12/19. The resident returned to the facility alert, cooperative, with no noticeable signs of injury, the police were notified and the entry and exit doors to the dementia unit were disarmed and would not be used by staff to enter and exit the unit.
   Review of a reportable event and investigation dated 10/12/19 at 10:30 AM identified that the resident ran out of the building behind a staff member Licensed Practical Nurse (LPN) #2, and the staff member did not realize that the resident was behind her. The resident was observed by a staff member, and when the staff attempted to stop the resident, h/she started to run, and crossed a highway, the staff followed until the resident could be redirected.
   Interview and observation with the DON, administrator, and Housekeeping Aide (HA) #1 on 11/18/19 at 9:30 AM at the location of where the resident crossed the highway identified a four way intersection, with four lanes, and a high traffic pattern.
   Observation and interview with the Director of Nursing (DON), Administrator, and the Director of Maintenance (DOM) on 11/18/19 at 10:00 AM identified that the locked dementia unit has 2 exit doors leading to the back parking lot. One door is a fire door and is only accessed in an emergency. The other door leads to the back parking lot, which is the door that Resident #1 exited through, and it is not wander guard equipped. The door has an alarmed delayed egress of 15 seconds. When the door is pushed an alarm sounds and after 15 seconds it will open, the door will alarm until a code is entered into the keypad. The DOM stated that the door can be opened by entering a code into the keypad, which allowed staff to enter and exit the unit from the back parking lot. The DOM further stated that up until Resident #1 had exited this door on 10/12/19, it was the main entrance and exit

for staff that worked on the locked dementia unit.
Interview with NA #2 on 11/19/19 at 1:05 PM identified that she had last seen the resident walking in the hallway around 9:30 AM.
Interview with LPN #2 on 11/19/19 at 10:06 AM identified that on 10/12/19 another resident had fallen, and when she determined that the resident had no injuries, she then went to her car to retrieve a stethoscope (although there was a stethoscope available on the unit). She exited the locked dementia unit by entering the code into the keypad which disarmed the door, and ran to her car to get the stethoscope. She identified that she did not see Resident #1 in the hallway at her time of exit, and although she did turn around to see if any resident had followed her out, she did not ensure that the door had completely closed, although she had been trained to do so.
Interview with the Administrator on 11/19/19 at 9:00 AM identified that the video of the incident was no longer available for review because the camera "loops", and it had been erased. He further identified that he had watched the video footage of the resident's exit on 10/12/19 and had determined that when LPN #2 exited the unit into the back parking lot, she did not look back and/or ensure the door was closed prior to turning her back and continuing to her car. After LPN #2 exited the door, the resident was seen exiting the door right before it closed entirely. The administrator further identified that any time a staff member exits the locked dementia unit they should ensure a resident has not followed them, and furthermore ensure the door is completely shut before turning their back and heading to the parking lot.
Interview with Nurse Aide #1 on 11/18/19 at 10:00 AM identified that she was providing care to another resident and saw a person in the parking lot through the window, and was not sure if the person was a resident, but thought h/she looked familiar. She stopped what she was doing and went outside where she saw Housekeeping Aide (HA) #1 in the parking lot, and stated that she did not know the resident's name but though it was a resident from downstairs (the locked dementia unit). HA#1 started to follow the resident, while she (NA #1) went to the dementia unit to inform the staff that a resident is outside, with HA#1 following the resident. The staff did a head count and determined it was Resident #1. NA#1 stated that she did not follow the resident, because she thought that HA#1 could "control" the resident better.
Interview with HA#1 on 11/18/19 at 9:30 AM identified that he was in the dining room washing the floor when he looked outside and saw who he thought to be a resident, but was unsure of the resident's name. He ran out of the building and attempted to get the resident back in to the building, but was unsuccessful, the resident was scratching and trying to kick him, so he followed the resident as he/she proceeded out of the facility driveway, and onto the sidewalk. When he got to the end of the driveway he called the facility to inform them that he was following the resident, and had asked a bystander to call 911. HA#1 identified that he followed the resident down the street. The resident started to run, and ran through a four way intersection of a four lane highway, and then tried to enter a church (which was locked), and ended up by the town hall (0.2 miles from the facility), the police and Registered Nurse #1 responded at that time and the resident was taken back to the facility.
Further interview with LPN #2 on 11/18/19 at 2:00 PM identified that as soon as it was identified that it was Resident #1 that had left the building she went outside to search the area around the facility along with NA #3. They did not know where the resident was located, only that HA#1 was following the resident.
Interview with Registered Nurse (RN) #1 on 11/18/19 at 2:25 PM identified that she was the

nursing supervisor on 10/12/19 when the resident eloped. She identified that she was notified by NA #1 that a resident was outside. They checked the unit and determined that it was Resident #1 who was outside. She came upstairs and went outside, and looked up and down the street, but did not see the Resident #1 or HA#1. She went back into the building and received a phone call from HA #1 that stated that he was following Resident #1 and made mention that someone had already called 911. She stated she can't recall exactly what she did when she came back into the building, but she thought that she may have called the police department for an update. A few minutes later the HA #1 called her and stated that the police had arrived, and Resident #1 was resisting when asked to return to the building, so she had gone to pick up the resident who returned to the facility. An assessment identified no injuries. RN #3 further identified that there was no "Dr. Hunt" called when the resident exited the building and 911 was not called by the facility because they knew the resident was with HA#1. RN #3 stated that she was not aware that LPN #2 and NA #3 went out to search for Resident #1.

Interview with the DON on 11/19/19 at 9:45 AM identified that the she was not notified on 9/22/19 that the Resident #1 had attempted to climb through a window, and would expect the nursing staff to put an intervention into place for the exit seeking behavior, but was unable identify that an intervention was initiated. She further identified that Resident #1 was last seen at 9:30 AM on 10/12/19, LPN #2 had gone to her car at approximately 9:50 AM, and the resident had exited the building shortly after, through the locked key padded door that was accessed by LPN #2. The resident returned to the building at approximately 10:30 AM. The DON identified that LPN #2 should have turned to check if there was a resident behind her and ensure the door was completely shut before turning her back to the door. The DON further identified that a "Dr. Hunt" and/or the facility calling 911 was not necessary because the facility knew that the resident was with HA#1, although the DON identified if a Dr. Hunt was called they would have had more staff members searching for the resident. The DON stated that after Resident #1 left through the door on 10/12/19, the keypads were immediately disabled, and all staff were told they could not use that door to enter and/or exit the unit, and a wanderguard audit was done on 10/14/19. The resident was also placed on every 15 minute checks until cleared by psychiatric services on 10/15/19.

The DON stated that education about staff looking behind to ensure a resident had not exited the door behind them, and that the door is completely closed was not done because there are signs on the door to remind visitors to ensure they only leave with the party they entered with. The facility had educated staff starting on 11/6/19 about checking behind and making sure the door locks behind them because with the inclement weather coming, they will be re-opening the doors for staff entry/exit.

Interview with Corporate Nurse (CN) #1 on 11/19/19 at 1:30 PM identified that the facility had not done an elopement drill since at least January 2018, and she was unsure of the reason. CN #1 further identified that she felt it was appropriate to have HA#1 follow the resident instead of NA#1 because all staff has dementia training.

The facility stated that they did not have a specific policy that addresses staff checking to ensure a resident has not followed them out, and ensuring that the door is completely closed while exiting the locked dementia unit, but all staff are trained to do so.

The facility failed to ensure a staff member that exited the building from the locked dementia unit was not followed by a resident who was at risk for elopement and had exit seeking behavior.

b. Resident # 3 had diagnoses that included dementia, anxiety, and depression.
A care plan dated 2/4/19 identified that the resident wandered often, with interventions that included a wander guard device to the left ankle.
A quarterly MDS dated 8/8/19 identified that the resident had moderate cognitive impairment, required extensive assistance with ADL's, and was independent with ambulation.
An elopement assessment dated 10/31/19 identified that the resident was at risk for elopement because of a previous history of elopement attempts, repetitively expressing desire to leave the facility, and exit seeking behavior.
Review of a physician's order dated 11/1/19 directed to have a wander guard to the left ankle and to check for placement every shift and check function daily on the 11:00 PM to 7:00 AM shift.
Review of the November 2019 Treatment Administration Record (TAR) identified that the wander guard was on the left ankle and was being checked for placement every shift, and was checked for function every night on 11:00 PM to 7:00 AM shift, in accordance with physicians orders.
Review of a nurse's note dated 11/15/19 at 7:32 AM identified that the resident was brought back to the unit by the supervisor after being found outside, wandering around the dumpster. The resident was wearing the wanderguard, but the alarm did not go off and/or the door did not lock. When the resident returned to the unit, the wander guard was tested and the alarm went off and the door locked.
Review of a reportable event dated 11/15/19 identified that the resident was noted outside the building by a facility vendor at 6:20 AM.
Review of timestamped camera footage (not equipped with sound) of the front door exit to the facility on 11/18/19 at 11:50 AM with the Administrator, and the DON identified that on 11/15/19 at 6:15:07 AM Resident #3 is approaching the front door, and at 6:16:00 AM, h/she starts to push on the door, and at 6:16:19 AM the door opens and the resident walks out the door and to the left, into the facility parking lot. At 6:17:49 NA# 4 is seen entering a code into the keypad, she then opens the door slightly, then closes the door, and then heads to the right and then is out of camera range. At 6:30:12 AM staff members are seen bringing the resident to the front door testing the wanderguard.
Review of the front door entrance to the facility with the DON on 11/18/19 at 1:30 PM identified that the front door is wander guard equipped and when a resident who is wearing a wander guard approaches the door the alarm will sound, and the door will lock for 15 seconds. If the door is pushed for 15 seconds, the door can be opened, with the alarm still sounding. The code must be entered into the keypad to silence the alarm. The DON further identified that the front door is unlocked allowing for staff entry at 6:00 AM, but this does not affect the wander guard system.
The temperature on 11/15/19 had a low of 26 degrees Fahrenheit, and sunrise was at 6:39 AM.
Interview with NA #4 on 11/19/19 at 7:06 AM identified that she was working on Resident #3's unit the morning of 11/15/19, and the unit is adjacent to the front door. She stated that she had noticed while conversing with a resident in the lobby, that the light on the door alarm box was green (identifying that the door was unlocked), and she thought it should be red (identifying that the door was locked). She identified that when she was at the keypad, she was entering the code in an attempt to lock the door, because she thought it should be locked until 7:00 AM, but she was unable to lock the door using the keypad, and left

because she figured that the staff would be entering the building for the first shift. NA#4 further identified that at no time was an alarm sounding, and when she was at the door alarm box, she was attempting to have the door lock, her actions had nothing to do with the wander guard alarm.

Interview with LPN#1 on 11/19/19 at 7:30 AM identified that he had checked Resident #3's wanderguard bracelet for function at the beginning of the 11:00 PM to 7:00 PM shift on 11/14 -11/15/19 and it was functioning appropriately. LPN #1 stated that he had last seen Resident #3 at 6:00 AM while administering medications. He identified that he was in the hallway from 6:00 AM until the resident was returned by the supervisor (around 6:30 AM) after being found outside. He stated that if the wander guard alarm sounds he can hear it in the hallway, and he did not hear any alarms sounding at any time during his shift.

Interview with NA #5 on 11/19/19 at 9:30 AM identified that she had seen Resident #3 around 4:00 AM on 11/15/19 AM on last rounds, and the resident was sleeping. NA#5 stated that although she can usually hear the front door alarm if it sounds, she did not hear the door alarm sound on that shift.

Interview with the Laundry Worker (LW) #1 on 11/19/19 at 12:15 PM identified that on 11/15/19 she was in the laundry room and the food delivery man came to the service door with Resident #1 and stated that he had found the resident in the parking lot. LW #1 identified that the resident was in his/her night clothes, but had a sweater on. She further identified that the resident was shivering and when she touched his/her hands they were cold. LW #1 stated that she took the resident to the nursing unit.

Interview with RN #2 (who is the 11:00 PM to 7:00 AM shift nursing supervisor) on 11/19/19 at 1:30 PM identified that on 11/15/19 LW#1 had brought the resident to her after h/she had been found outside, she noted that the resident's hands were cold. RN #2 completed an assessment, and no injuries were identified. She then took the resident to the front door and tested the wander guard and the alarm rang loudly, the door locked, and it was identified that the wander guard and door were functioning properly at that time.

Interview with the Service Manager (SM) at Secure Care (distributor that provides the wander guard system to the facility) on 11/19/19 at 2:35 PM identified that the only way to silence the wander guard alarm is to enter the code into the key pad. He further identified that if the front door was unlocked at the time the resident exited, and the door had locked for the 15 seconds before the resident was able to exit, it would appear that the wanderguard system was functioning. But if there was no sound on the video, you could not determine if the alarm had sounded. The SM further identified that it would be recommended to call the service company any time an issue with the wander guard system is identified.

Interview and review of the facility daily door checks with the Administrator and the DOM on 11/19/19 at 1:45 PM identified that he checks all doors for proper function every day, and checks the function of the wander guarded doors daily using the tester unit. Review of the daily door checks with the DOM identified that the door checks were not completed on 11/14/19 (the day prior to the elopement). The DOM identified that he was off on 11/14/19, and his assistant would have usually completed the door checks in his absence but he was no longer employed at the facility. The Administrator identified that the doors were checked on 11/15/19 after the elopement by facility staff, and were functioning correctly, but they did not contact the service company to come to the facility and check the system.

Review of the daily door checks from 7/2019 through 11/18/19 identified that the doors and/or wanderguard system were not checked on 53 days during that time period, and the DOM stated that he does not check the doors on the weekends and the days that he is off.

The Administrator identified that he was unaware that the door/alarms were not being checked in the DOM's absence, and should be checked daily.
Subsequent to surveyor inquiry on 11/19/19 the administrator identified that housekeeping would now be in charge of checking the doors/alarms in the DOM's absence.
Interview with the DON on 11/19/19 at 2:00 PM identified that after the resident eloped the resident was taken to the front door and the resident's wander guard and the door was functioning properly, and the alarm sounded loudly. The DON further identified that it was unclear how the resident was allowed to exit the building through the wander guard secured door. The DON identified that although the facility was not sure how the resident was allowed to exit, the facility completed a wanderguard audit, and educated staff on responding to alarms when sounding, and on the elopement policy on 11/15/19.
Review of the elopement risk policy identified that the maintenance department is responsible for testing door alarms and keypads utilizing the tester unit, in the absence of the maintenance staff the Administrator will be responsible for ensuring a staff member in the facility is assigned to perform the testing of the door alarms and keypad utilizing the tester unit. The daily testing will be documented in the maintenance log.
The facility failed to ensure that the wander guard system was checked daily for functioning, and that a resident who was at risk for wandering and was wearing a wander guard device exited the building through a wander guard equipped door without staff knowledge on 11/15/19 at 6:00 AM.

c. Resident #2 was admitted to the facility on 8/26/19 and had diagnoses that included vascular dementia with behavioral disturbance and a generalized anxiety disorder.
An elopement risk assessment dated 8/26/19 identified that the resident was at risk for elopement due to repetitively expressing the desire to leave the facility and exit seeking.
A care plan dated 8/27/19 identified that the resident was at risk for elopement due to frequent wandering with interventions that included to apply a wander guard, check placement and function per policy, and to redirect if seen heading to an exit door.
An admission MDS dated 9/11/19 identified that the resident had severe cognitive impairment, required limited assist with ADL's, was independently ambulatory, and wandered daily which put the resident at significant risk for getting to a potentially dangerous place.
Review of a nurse's note dated 9/22/19 at 6:19 PM written by RN #3 (the nursing supervisor) identified that a NA who was on the oncoming shift informed her that Resident #2 was standing outside a window on the lower level. Upon arrival the resident was seen in the patio area outside the lounge window, the window was open with the screen seen on the patio. The resident was brought back inside and was noted to be limping and stated that h/she had fallen on his/her left knee when h/she climbed out of the window. Ice was applied and an x-ray ordered. Maintenance was notified and the window was secured.
A reportable event dated 9/22/19 identified that the resident had climbed out a window and fell onto his/her knee.
A nurse's note dated 9/23/19 identified that the x-ray to the left knee was negative.
Interview with NA # 6 on 11/19/19 at 9:00 AM identified that when she came to work on 9/22/19 around 2:45 PM she observed Resident # 2 outside on the patio. She immediately went to the resident and called the facility from her cell phone, and stayed with the resident until the staff arrived.
Interview with LPN #3 on 11/18/19 at 2:10 PM identified that she was Resident #2's regular charge nurse on the locked dementia unit. She stated that the day prior to the elopement

(9/21/19) she was doing rounds sometime before 7:00 AM and when she entered Resident #2's room, the glass window was on the floor. It appeared that the resident had removed the window from the frame. LPN #3 stated that she had removed the glass window from the resident's room and reported it to the supervisor, and a short time later the DOM arrived and bolted the window shut. LPN #3 stated that on 9/22/19 she was in the hallway and another resident attempted to communicate with her, although unclear, it appeared she was trying to get her to go to the patio area. LPN #3 went to the lounge and saw NA #6 standing outside with Resident #2 outside on the patio. The resident was brought inside and an assessment was completed. A bruise was noted to the left knee, ice was applied and an x-ray was ordered.

Interview with RN #3 (nursing supervisor) on 11/19/19 at 12:05 PM identified that on 9/22/19 she received a call from staff that Resident #2 was outside the building on the patio. By the time she arrived LPN #3 was already inside with the resident. She stated that she called the DOM and he came in immediately and secured all of the windows on the dementia unit. RN #3 stated that she was not told that the resident had removed the window on 9/21/19, and she only heard about the incident in nursing report. She further stated that she did not notify maintenance of the event on 9/21/19.

Interview and observation with the DOM of Resident #2's window on 9/18/19 at 9:15 AM identified that on 9/21/19 he was informed by RN # 3 that the resident had removed the window from the frame, (although RN #3 stated that she was not aware of the incident). He came in soon after and bolted Resident #2's window shut with an "L" bracket and 2 screws. He further identified that the next day he received another call from RN #3 and was told the resident went through the lounge window. He explained that the resident was able to lift the window above the screw that was placed there to prevent the window from opening more than 6 inches, allowing him/her to exit the window. He came in that day and after a discussion with the Administrator decided to secure all of the windows on the unit. Observation of windows on the secured unit identified that they are now completely secured and do not allow for the window to be opened at all.

Interview with the DON on 11/19/19 at 1:00 PM identified that she was not aware that the resident had removed the window on 9/21/19, and stated that although Resident #2's window was secured, all the other windows on the unit were not, and it would be possible for her to exit one of those windows, as she had her own. She stated that although she did not feel increased supervision for Resident #2 was necessary after removing the window on 9/21/19, she would likely have directed for all the windows on the unit to be secured to prevent the resident from going out another window.

Review of the elopement risk policy identified that all residents will have interventions instituted.

The facility failed to ensure that a resident who had active exit seeking behavior had appropriate interventions in place to prevent an elopement.

Plan of Correction for Violation #2:

1. **All residents that are at risk for elopement have the potential to be affected by this practice. The facility ensures that residents who have exit seeking behaviors do not follow staff outside the facility and have appropriate individualized interventions in place and that wander guard system and doors are checked daily for proper functioning. Maintenance and housekeeping will be educated on elopement policy and policies**

regarding checking wander guard system and checking doors daily for proper functioning. Nursing staff will be educated on elopement policy and procedures including alarm system. Licensed nursing staff will be educated on implementing individualized interventions when resident is exhibiting exit seeking behaviors.

2. **12/31/19**
3. **The administrator or designee will conduct weekly audit to ensure doors and wander guard system is being checked by maintenance/housekeeping daily. The Administrator or designee will conduct 3 random mock drills of elopement to ensure staff follows facility protocol for elopement. The DNS or designee will conduct weekly audit of residents with exit seeking behaviors to ensure plan of care is updated with individual interventions when resident is exhibiting exit seeking behaviors. Audits will be reviewed and QA as needed.**
4. **Administrator or designee**

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3).

2. Based on facility documentation, interviews, and policy review, the facility failed to conduct daily door checks in accordance with facility policy. The findings include:
   a. Review of the daily door check documentation from 7/2019 until 11/18/19 identified that daily doors checks were not completed in accordance with facility policy. In July 2019 and August 2019 door checks were not completed on 11 days during each month. In September 2019 door checks were not completed on 13 days, in October 2019 door checks were not completed on 10 days, and up until November 18 2019 there were 8 days where the daily door checks were not completed.
   Interview with the Director of Maintenance (DOM) on 11/19/19 at 11:30 AM identified that the door checks include checking the keypads for function, checking the alarmed doors for function and ensuring that the wander guard system is functioning correctly. He further identified that he does not do the door checks on the weekends because he does not work the weekends, and he was not sure who checked the doors on his days off.
   Interview with the Administrator on 11/19/19 at 11:32 AM identified that the door checks should be completed daily, and he thought the nursing supervisor was checking the doors in the DOM's absence.
   Subsequent to surveyor inquiry on 11/19/19 the administrator identified that the housekeeping staff would be checking the doors in the DOM's absence.
   Review of the elopement risk policy identified that the Maintenance department is responsible for daily testing door alarms and keypads utilizing the tester unit, in the absence of the maintenance staff, the administrator is responsible for ensuring a staff member is assigned to perform door testing daily.

Plan of Correction for Violation #3:

1. **All facility doors have the potential to be affected by this practice. The facility ensures that all facility doors are checked per facility policy. Maintenance and housekeeping will be educated on ensuring all facility doors are checked in accordance with facility policy.**
2. **12/31/19**

3. **The administrator or designee will conduct weekly audit to ensure doors are being checked daily per facility policy. Audits will be reviewed and QA as needed.**
4. **Administrator or designee**