STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075352	A. Building B. Wing	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Connecticut Baptist Homes, Inc	292 Thorpe Avenue Meriden, CT 06450

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 3 of 4 residents (Resident #42, 9 and 7), reviewed for accidents, for Resident #42 who had severely impaired cognition, a history of falls and was at high risk for elopement, the facility failed to monitor and accurately document the residents location in the facility every 15 minutes according to the plan of care which resulted in the resident being able to exit the facility (elope) unsupervised. These failures to properly monitor and accurately document the resident's location in the facility allowed the resident to elope the facility and resulted in a finding of Immediate Jeopardy. Additionally, for Resident #9, the facility failed to ensure the resident was transferred according to the physician's order resulting in a fall with an injury, and for Resident #7 the facility failed to ensure the staff used a gait belt during a transfer. The findings include: 1. Resident #42 was admitted to the facility with diagnoses that included Alzheimer's disease, anxiety, dementia with behavioral disturbances, violent behaviors, and difficulty walking. The quarterly MDS dated [DATE] identified Resident #42 had severely impaired cognition, rejects care, has behaviors such as pacing 1 - 3 days a week and ambulates with supervision or touching assistance with a walker. The care plan dated 1/12/24 identified Resident #42 wanders, was at risk of elopement and has a history of attempts to leave the facility unattended. Interventions included ensuring a stop sign on the exit door to the stairwell, monitoring the resident's location every 15 minutes and documenting the wandering behavior and attempted diversional interventions on the log. Elopement/wander assessment dated [DATE] identified Resident #42 was at high risk for elopement. The physician's order dated 5/6/24 directed Resident #42 required supervision for transfers and ambulation with a wheeled walker. Review of the every 15 minute check form dated 6/1/24 at 4:00 PM, completed by NA #6, identified Resident #42 was in his/her bed in his/her room. (This is in conflict with the surveillance video that shows that at 3:59 PM Resident #42 was walking in the hallway, rounding the corner toward the residential care unit). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the every 15 minute check form dated 6/1/24 at 4:15 PM, completed by NA #6, identified Resident #42 was in a chair in his/her room. (This is in conflict with the surveillance video that shows that at 4:01 PM Resident #42 exited a door to the patio area outside). Review of the every 15 minute check form dated 6/1/24 at 4:30 PM, completed by NA #6, identified Resident #42 fell outside. (This is in conflict with the surveillance video that shows that at 4:34 PM Resident #42 was outside, alone, walking down the driveway that goes up a hill to the residential houses and at 4:35 PM Resident #42 gets down the driveway, passes the trees and went out of camera sight). The nurses note, written by RN #1, dated 6/1/24 at 11:41 PM identified that at approximately 4:30 PM a nurse aide informed this writer that Resident #42 was outside the building and possibly fell. This writer checked on the resident, who was laying on the grass outside. Per the nurse aide, Resident #42 was seen holding a pillow while walking outside the building near the residential living parking lot area. Assessment indicated no abrasions or bruises noted to body. Resident #42 was assisted off the ground with a gait belt, was able to stand and walk without issue, ambulated back to the building, and was placed in a wheelchair. The resident will continue to be closely monitored for safety every 15 minutes. Resident representative updated and verbalized concern with resident's safety. The DNS was made aware of the incident and resident representative's concerns. Interview with the DNS on 6/3/24 at 8:15 AM indicated that she feels the facility has used all interventions related to Resident #42's falls and wandering and that was why Resident #42 was placed on every 15-minute checks for safety. The DNS indicated that Resident #42 doesn't come out of the room during the day but in the evening sometimes will sit in the hallway in a common area. The DNS indicated that the wander guard system is only for residents on the 3rd floor, long term care unit. Interview with NA #6 on 6/3/24 at 9:05 AM indicated that she worked on Saturday 6/1/24 from 3:00 PM until 11:00 PM. NA #6 indicated when she came in at 3:00 PM Resident #42 was wandering in and out of his/her room and wandering back and forth near the nursing station. NA #6 indicated she started rounds and was making the bed in a room at the end of hallway when she saw Resident #42 through the window walking outside in the rear parking lot with his/her pillow. NA #6 got NA #4 and they went down the stairwell outside to find Resident #42 across the parking lot from the facility laying down on the grass under a tree with the pillow completely under his/her back. NA #6 indicated that Resident #42 indicated he/she was sleeping there. NA #6 indicated she ran back to the facility to get the charge nurse. NA #6 indicated they used the gait belt and assisted Resident #42 off the ground and Resident #42 walked back to the building almost to the back door and turned around to go back away from the facility. NA #6 indicated the nurse went into the facility to get a wheelchair for the resident. NA #6 indicated that Resident #42 was all the way on the other side of the back parking lot, over the curb in the grass under the tree near the driveway to the residential houses. NA #6 indicated she did not see when or where Resident #42 had left the facility. Interview with RN #3 on 6/3/24 at 9:50 AM indicated Resident #42 was at high risk for elopement. RN #3 indicated that Resident #42 was at the end of the hallway but wandered up and down the hallway and almost daily would try to go out through the stairwell at the end of hallway by his/her room. Staff put up a stop sign across the stairwell door until the lock with a keypad came in, so Resident #42 couldn't open the door. RN #3 indicated that Resident #42 has attempted to leave the unit before but had not had an elopement and that was why Resident #42 was on every 15-minute checks to monitor his/her location. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the DNS on 6/3/24 at 10:30 AM indicated that Resident #42 did not elope on 6/1/24 because he/she never left the facility property and did not fall because Resident #42 indicated that he/she laid down with the pillow. The DNS indicated that Resident #42 had severe cognitive impairment but to her it was obvious that Resident #42 had taken the pillow to purposefully go outside to lay down in the grass with the pillow. The DNS indicated that Resident #42 was on every 15-minute checks for safety due to wandering. The DNS indicated that she did not know how big the property was other than it had a short and long-term care facility, residential living facility, and up in the back area were residential homes. The DNS indicated that she believes Resident #42 was last seen on 6/1/24 at 4:15 PM and was then seen outside at 4:30 PM. The DNS indicated that she could not say how long Resident #42 was outside before NA #6 saw Resident #42 through the second-floor window. Interview with the DNS on 6/4/24 at 10:28 AM indicated that since admission Resident #42 has been at high risk for elopement and interventions were to try to keep him/her in common areas while awake, have him/her join activities, land redirect if walking around. The DNS noted on 8/21/23 Resident #42 was found outside of facility. The DNS indicated that Resident #42 was placed on every 15-minute checks and a stop sign on the stairwell door until the lock could be installed. The DNS indicated that she had not done an investigation or watched the video surveillance to investigate when Resident #42 had left the facility and when he/she was found. The DNS indicated that the nursing supervisor had called and informed her that Resident #42 had left the facility out the residential living exit doors and a nurse aide had seen Resident #42 in the parking lot outside of the facility walking. When staff arrived outside Resident #42 was found lying on the grass under a tree with a pillow. The DNS assumed it was the tree closest to the exit door approximately 30 feet from exit door. The DNS indicated that the expectation was that the nurse aides would visually check and see Resident #42 every 15 minutes, and then would document the location and what Resident #42 was doing. Observation of the surveillance video for 6/1/24 with the DNS and the Maintenance Director on 6/4/24 at 11:15 AM identified the following: At 3:59 PM Resident #42 was walking in the hallway, rounding the corner toward the residential care unit with a pillow and without a walker. At 4:01 PM Resident #42 exited the right-hand side door to the patio area outside and then was out of camera surveillance site. At 4:28 PM the resident was seen on the camera on the parking lot side looking down to the end of the building where the maintenance garage area is. At 4:29 PM Resident #42 appears and stopped when walking in the parking lot against the stone wall on the opposite side of the facility. At 4:29 and 45 seconds Resident #45 stumbles twice and lays down on the small grassy area in the parking lot away from the facility. At 4:34 PM Resident #42 was back to standing position and started walking down the driveway that goes up a hill to the residential houses towards the other end of the facility. At 4:35 PM Resident gets down driveway, passes the trees and went out of camera sight. At 4:37 PM and 30 seconds a staff member is seen coming from the end of the driveway towards the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	facility. The DNS indicated that was the nurse aide coming into the facility to get the nurse. At 4:47 PM the nurse exited the facility with the wheelchair, had Resident #42 sit in the wheelchair and was seen pulling Resident #42 backwards in the wheelchair into the facility. The DNS indicated that Resident #42 was to ambulate with supervision using a wheel walker and during video there was no walker or staff assistance. The DNS indicated that Resident #42 does not remember to take the walker that staff must give it to him/her. The DNS indicated that Resident #42 had left the facility at 4:01 PM and was not seen by the staff until at least 4:36 PM. The DNS indicated that no one had witnessed Resident #42 go from a standing position to laying on the ground, but she felt Resident #42 did it on purpose. The DNS indicated that she was not aware prior to watching the video with the surveyor how long Resident #42 had been unattended outside of the facility. Although attempted, an interview with NA #6 was not obtained. Review of the facility Elopement Policy identified the facility strives to promote resident safety and protect the rights and dignity of the residents. Elopement is defined as the ability of a resident who is not capable of protecting him/herself from harm to successfully leave the facility unsupervised and unnoticed and who may enter harm's way. Prevention would include frequent monitoring of the resident's whereabouts to assure he/she remains in the facility with every 15-minute checks, cameras are in place that continually monitor all the exits in the building, elevator controls, restricted window openings. When a resident has been found the search Director or DNS will notify all staff that the resident has been found and the charge nurse will examine the resident for injuries. The Physician and resident representative will be notified. The care plan will be updated. Implement every 15-minute checks for safety. Complete a Missing Resident form and required staff present and involved to sign the form. Report the incident to the state authorities as required. 2. Resident #9 was admitted to the facility in November 2019 with diagnoses that included hemiplegia and hemiparesis affecting left non-dominant side, cerebral infarction, heart failure, and atrial fibrillation. A physician's order dated 1/12/23 directed to provide the assistance of 2 for transfers from bed to/from wheelchair with hemi walker. The care plan dated 3/22/23 identified Resident #9 was at risk for falls related to gait/balance problems and left sided weakness. The April 2023 monthly physician's orders directed to transfer the resident with the assistance of 2 from bed to/from wheelchair with hemi walker, no ambulation. The fall assessment dated [DATE] identified Resident #9 was at high risk for falling. The annual MDS dated [DATE] identified Resident #9 had intact cognition and required extensive 2-person assistance with transfers. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The care card, without a revision date, identified to transfer Resident #9 with the assistance of 2 with hemi walker. The May 2023 monthly physician's orders directed to transfer the resident with the assistance of 2 from bed to/from wheelchair with hemi walker, no ambulation. The nurse's note dated 5/11/23 at 11:46 PM identified RN #1 was notified by LPN #1 at 6:30 PM that Resident #9 had fallen. RN #1 observed Resident #9 on the bedroom floor with an L shape laceration on the left mid part of the head that measured 5cm x 0.2cm with moderate amount of bleeding. Resident #9 was alert and verbally responsive complaining of pain to the head and back area with no shortening/lengthening of bilateral legs. A cold compress was applied to the wound area to control the bleeding. Neurological checks and vital signs were initiated and were within normal limits. The physician was notified and ordered Resident #9 to be sent to the hospital for further evaluation. The reportable event form dated 5/11/23 at 6:30 PM identified Resident #9 was being assisted with a transfer of 1 staff and the hemi walker from the wheelchair to the bed and lost his/her balance, struck his/her head on the floor and sustained a laceration on the back of the head. Pressure was applied to the back of the head and Resident #9 was transferred to the hospital for treatment. Review of a statement written by NA #1 dated 5/11/23 identified she was transferring Resident #9 from the wheelchair to the bed. NA #1 indicated she was in front of Resident #9 holding on to his/her clothing. Resident #9 was holding onto the hemi walker and lost his/her balance and fell on his/her back. Review of the hospital inter-agency patient referral report (W-10) dated 5/11/23 identified Resident #9 was seen for a fall and head laceration repair. Resident #9 is to follow up with primary physician regarding wound and staples removal. The revised care plan dated 5/11/23 identified Resident #9 was at risk for falls related to gait/balance problems and left sided weakness. Resident #9 fell on 5/11/23 and sustained an injury to the head. Interventions included transferring Resident #9 to the hospital for evaluation and treatment. Physical therapy to evaluate and treat as indicated. Review of the education sheet dated 5/12/23 identified the use of gait belt was reviewed with NA #1. All residents that are ambulated and transfer with assist of 1 or 2 must have a gait belt placed around them and used to guide and stabilize the resident. If the nurse aide gait belt is not available there are gait belts at the nursing station for use. NA #1 was given a gait belt. The care plan dated 5/12/23 identified Resident #9 sustained a laceration on the left side of the head that required 10 staples to repair. Interview with MD #1 on 6/3/24 at 10:55 AM identified the nursing staff should have followed the physician's order to provide assistance of 2 when transferring the resident. Interview and review of the clinical record with the Physical Therapy Director on 6/3/24 at 11:00 AM identified Resident #9 was on therapy with activity orders to provide the assistance of 2 for transfers bed to/from wheelchair with hemi walker. Interview with NA #1 on 6/4/24 at 10:40 AM identified she was only employed at the facility for 1 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	month when Resident #9 fell, and it was her first-time providing care to Resident #9. NA #1 indicated she did not read the care card before transferring Resident #9 and she did not utilize a gait belt during the transfer. NA #1 indicated she did not check the care card and does not know what the care card directs for transfers for Resident #9. NA #1 indicated Resident #9 stood up and let go of the hemi walker and fell backward on the floor. NA #1 indicated Resident #9 was bleeding from his/her head. Interview and review of the clinical record with the DNS on 6/4/24 at 11:43 AM identified while conducting the investigation she called NA #1 who stated she transferred Resident #9 by herself and without a gait belt. The DNS indicated NA #1 should have used a gait belt and had the assistance of 2 persons with the transfer from the wheelchair to bed. The DNS indicated she educated NA #1 regarding the gait belt and reviewing the care card before providing care to a resident. The DNS indicated NA #1 was unable to state the reason why she did not use a gait belt and read Resident #9 care card. Review of the fall management and prevention policy identified to ensure that all residents are assessed for fall risk and that adequate measures are taken to prevent injuries due to falls. Residents will be assessed for fall risk using the Morse fall risk assessment form on admission, quarterly thereafter and with a change of condition. If the resident is at risk for falls, interventions to reduce this risk will be included in the resident's care plan. Review of the facility safe patient/resident handling policy identified to enhance the safety of the work environment for resident care providers and promote a safe, secure and comfortable experience for residents who require partial or full transfer assistance. An interdisciplinary team will evaluate and assess each resident's individual mobility needs. Resident mobility assessments will be performed or reviewed on admission, after a significant change in condition or based on direct care staff recommendations. Safe resident handling and moving requirements: All lifting and transferring of patients/residents will be performed according to their individual plan of care. Gait belts are a tool for gait stabilization - not lifting or moving residents. 3. Resident #7 was admitted to the facility on [DATE] with diagnoses that included stroke, osteoarthritis, hypertension. The care plan dated 12/12/23 identified Resident #7 was at high risk for falls due to deconditioning. Interventions included dycem to wheelchair to prevent sliding and call light in reach. The quarterly MDS dated [DATE] identified Resident #7 had intact cognition, required maximum assistance with personal hygiene, toileting, bathing, and dressing, was totally dependent on staff for transfers and utilized a wheelchair for mobility. Further, Resident #7 had no behaviors and no history of falls in the last 6 months. A physician's order dated 2/14/24 directed to provide the assistance of 1 for transfers from the (continued on next page)

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