| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225281 | A. Building<br>B. Wing | 01/15/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Skilled Nursing Facility at North Hill (the) | 865 Central Avenue<br>Needham, MA 02492 |

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 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37330<br><br>Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was newly admitted to the Facility, was confused, was noted to wander without regard for his/her own safety, the Facility failed to ensure he/she was provided with quality care and services that meet professional standards of practice. When although he/she was assessed by two different nurses upon admission as triggering for placement of a WanderGuard bracelet for safety, a device was not placed on him/her, and despite his/her continual wandering day and night, nursing did not reassess or re-evaluate their decision regarding placement of a WanderGuard. On [DATE], unbeknownst to staff, Resident #1 wandered off his/her unit, took the elevator to the Lobby and exited out the front door of the Facility, undetected by anyone. While outside, Resident #1 fell landed face down, hitting his/her head on the ground. Resident #1 was diagnosed with significant intracranial hemorrhaging (bleeding in the brain) and died eight days later.<br><br>Findings include:<br><br>The Facility's Policy titled, Elopement Risk Assessment & Prevention Policy and Procedure, dated , d+[DATE], indicated it is Policy of the Facility to establish and maintain standard protocols for the purpose of ensuring that each Resident residing in the Facility is appropriately assessed for risk of elopement, and utilizing an industry standard of practice Elopement Assessment Tool. The Policy indicated if an individual Resident is found at risk for elopement, appropriate interventions are implemented to decrease the potential for intentional or unintentional elopement from the Facility or campus premises.<br><br>The Policy indicated assessment intervals include upon moving into the Facility each Resident is assessed to establish a baseline and determine risk for elopement. The Policy indicated this is completed by the Admitting Nurse and then subsequently by the Minimum Data Set (MDS) Coordinator or the Licensed Team Member designated by the MDS Coordinator and this assessment will also be completed if there is a change in a Resident's wandering patterns.<br><br>The Policy indicated Residents which have the following are considered potentially at risk for elopement; Residents taking medications which potentially cause confusion or disorientation and Residents with indicators of Dementia. The Policy indicated those Residents found to be at risk for elopement from the Facility or the campus will have a WanderGuard bracelet placed on one or more of the following areas: wrist, ankle, mobility device, such as a walker or wheelchair. Residents who are found at risk of elopement will have 2 of their photos pulled or copied from their record and placed at the Facility's Receptionist desk in the WanderGuard Book.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on [DATE] at 8:24 A.M., the Maintenance Director said the Facility is equipped with a WanderGuard alert system, that alarm sensors are in place at the elevator that prevents a resident wearing a WanderGuard device from accessing and using the elevator without a staff member present, and also prevents the resident from going through or out any door in the facility equipped with a sensor, unless they are accompanied by staff, who must temporarily disable the sounding alarm triggered by a resident wearing a WanderGuard device as they get within range of any of the WanderGuard alarm sensors.<br><br>Review of the Facility Incident Report, dated [DATE] at 5:45 P.M., indicated that Resident #1 was observed by Certified Nurse Aide (CNA) #2 standing up from the dining table and had been unsteady on his/her feet. The Report indicated Resident #1 did not want to sit back down in his/her seat, therefore CNA #2 assisted Resident #1 and walked around the unit with him/her. The Report indicated CNA #2 escorted Resident #1 to the television room, where there was a Dietary Aide located at the time. The Report indicated CNA #2 left the room to assist another resident and the Dietary Aide left the television room.<br><br>The Report indicated that at approximately at 6:09 P.M. Resident #1 exited the front door of the Facility and at 6:12 P.M. the Administrator and Director of Nurses (DON) observed Resident #1 outside, on the sidewalk in front of the building. The Report indicated that they observed Resident #1 placing his/her walker over the curb resulting in a witnessed fall. The Report indicated Resident #1 sustained lacerations to the left side of his/her forehead and top of his/her nose. The Report indicated first aid had been provided and Resident #1 was sent to the Hospital.<br><br>Review of Resident #1's Hospital Admission Note, dated [DATE], indicated Resident #1 sustained a Petechial Hemorrhage (9 mm) within the known left temporoparietal infarct (a significant intracranial hemorrhage, brain bleed), left frontal scalp hematoma, and unchanged bilateral hypodense subdural collections, likely hygromas (fluid collection in the subdural space on both sides of the brain that appear low in density).<br><br>The Hospital Note indicated Resident #1 had been on Eliquis (anticoagulant, 5 milligrams two times a day) at the time of the fall, has significant intracranial hemorrhaging, with the potential for life-threatening progression or permanent disability and was transferred to another Hospital for further treatment.<br><br>During an interview on [DATE] at 9:27 A.M., Family Member #1 said Resident #1 died on [DATE] (eight days later) as a result of his/her injuries, sustained from the fall.<br><br>Resident #1 was admitted to the Facility in [DATE], diagnoses included Left Cerebral Vascular Accident (stroke) with right hemiparesis (muscle weakness or partial paralysis on one side of the body), Altered Mental Status, Aphasia (a disorder that affects how you communicate), Type II Diabetes with long term use of Insulin, Atrial Fibrillation (irregular/rapid heart rate), Urinary Tract Infection, Hypothyroidism (thyroid gland does not produce enough thyroid hormone), Hypertension (High Blood Pressure), and Insomnia (persistent problem falling and staying asleep).<br><br>Resident #1's Admission Fall Risk Assessment, dated [DATE], indicated Resident #1 was assessed by Nursing as being at High Risk for falls, factors included intermittent confusion, history of falls, balance problems while standing and walking, decreased muscular coordination with required assistance (person and device), and prescribed medications that increase his/her risk to falls.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Resident #1's Baseline Care Plan titled Falls, dated as initiated on [DATE], indicated Resident #1 was at risk of falling, had short/long term memory problems, was moderately cognitively impaired (stage of decline that affects short-term memory and the ability to complete complex tasks) and required one staff member assistance with transfers and mobility.<br><br>Review of Resident #1's Admission Assessment, which included a brief Wandering Assessment component, dated [DATE], indicated he/she was assessed by Nurse #1 for the need for placement of a WanderGuard bracelet device. The Assessment directed Nurse #1 to consider placing a WanderGuard on the Resident if Yes was the response to Any of the following:<br><br>- (a) new admission<br><br>- (b) Resident independently in mobility<br><br>- (c) Resident resistant to being placed in the facility<br><br>- (d) Resident have a history of wandering<br><br>- (e) he/she had been taking medications which cause confusion or disorientation<br><br>- (f) any indications of Dementia.<br><br>Further review of the Assessment indicated that although Nurse #1 documented Yes as the response to 1 of the 6 indicators listed above, (a) new admission, the decision was made by Nurse #1 NOT to place a WanderGuard on Resident #1.<br><br>The Assessment also required the nurse completing it to document Why if the device was not placed on the Resident, however that part of the Assessment was left blank and no rationale was provided by Nurse #1.<br><br>During a telephone interview on [DATE] at 9:26 A.M., Nurse #1 said on [DATE], he was assigned to and completed Resident #1's Admission. Nurse #1 said Resident #1 had a difficult time communicating and expressing his/her needs. Nurse #1 said Resident #1 was unsteady on his/her feet, Resident #1's body movements were slow, he/she was weak and he/she needed staff assistance for mobility. Nurse #1 said that although the assessment recommended to consider putting a WanderGuard on Resident #1, said that he felt Resident #1 did not need it.<br><br>Review of an additional more detailed Wandering/WanderGuard Assessment for Resident #1, dated [DATE], and completed by Nursing Supervisor #1, indicated she also assessed him/her for the need for placement of a WanderGuard device. The Assessment also directed Nursing Supervisor #1 to consider placing a WanderGuard on the Resident if Yes was the response to Any of the following:<br><br>- (a) new admission<br><br>- (b) able to walk independently<br><br>- (c) able to walk with walker or use wheelchair<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | - (d) able to walk with the assistance of others<br><br>- (e) Resident resistant to being placed in the Facility<br><br>- (f) Resident has history of wandering<br><br>- (g) he/she had been taking medications which cause confusion or disorientation<br><br>- (h) any indications of Dementia.<br><br>Further review of the Assessment indicated that although Nursing Supervisor #1 documented Yes as the response to 6 of the 8 indicators listed above, (a, b, c, d, g, h), the decision was made by Nursing Supervisor #1 NOT to place a WanderGuard on Resident #1. The Assessment also required nursing to document Why if the device was not placed on the resident, however that part of the Assessment was left blank and no rationale was provided by the Nursing Supervisor #1.<br><br>During a telephone interview on [DATE] at 1:07 P.M., Nursing Supervisor #1 said on [DATE] she helped Nurse #1 with Resident #1's Admission. Nursing Supervisor #1 said Resident #1 recently had a stroke and he/she had difficulty finding words. Nursing Supervisor #1 said she observed Resident #1's mobility with the assistance of Physical Therapy and said Resident #1 had difficulty with walking.<br><br>Nursing Supervisor #1 said on [DATE] she completed Resident #1's Wandering/WanderGuard Assessment which was a separate document from the Admission and Assessment for Resident #1 that was completed by Nurse #1. Nursing Supervisor #1 said she did not communicate her findings of Resident #1's Assessment to Nurse #1. Nursing Supervisor #1 said Resident #1 was unsteady on his/her feet, and needed staff assistance with ambulation.<br><br>Nursing Supervisor #1 said when she completed Resident #1's Wandering/WanderGuard Assessment, she did not document the reason why she decided Resident #1 did not need a WanderGuard and said all the questions on the Assessment including Why were to be completed as required. Nursing Supervisor #1 said she decided not to put the WanderGuard on him/her because he/she really could not walk independently.<br><br>Nursing Supervisor #1 said it was confusing when completing the Facility's Resident Admission and Assessments including the Wandering/WanderGuard Assessment if the Resident was able to walk, but was not independent.<br><br>Review of Nurse #1's Admission Progress Note, dated [DATE], indicated Resident #1's gait was slow and weak, that he/she required a rolling walker, and one staff member assistance was needed with transfers. The Note indicated Resident #1 needed frequent checks to prevent falls/injury, due to Resident #1's confusion.<br><br>Review of Nurse's #1's Progress Note, dated [DATE], indicated Resident #1 was resistive to care, because of his/her impaired memory, he/she had an unsteady gait, was non-complainant with safety measures and Resident #1 required close supervision.<br><br>Review of Nurse's #1's Progress Note, dated [DATE], indicated Resident #1 remains at High Risk for Falls due to confusion and poor balance.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of Nurse's #2's Progress Note, dated [DATE], indicated Resident #1 continues to wander all evening, with standby assist and cueing required for safety.<br><br>During an interview on [DATE] at 2:27 P.M., (and during a follow-up interview on [DATE] at 11:04 A.M.) the Occupational Therapist Assistant (OTA) said on [DATE] she observed Resident #1 ambulating with his/her walker, and that Resident #1 attempted to push open the door located on the far end of the unit. The OTA said she approached Resident #1 and distracted him/her from trying to exit the unit. The OTA said Resident #1 had a difficult time talking, verbalizing his/her needs and wants, was confused about his/her surroundings and had trouble following one step directions. The OTA said she had walked with and brought Resident #1 to the television room on the unit.<br><br>The OTA said she spoke with Resident #1's Nurse (exact name unknown) to let her know what had occurred and said the Nurse directed her to inform the Director of Nurses (DON). The OTA said that day, she reported to the DON that she had observed Resident #1 wandering on the unit and that he/she was attempting to exit the unit. The OTA said the DON informed her that she would start a Behavioral Log on Resident #1. The OTA said she documented in Resident #1's Therapy Note on [DATE] what she had observed and that she had reported the incident.<br><br>Review of a Nursing Progress Note, dated [DATE], indicated Resident #1 continues to wander all night.<br><br>Further review of Resident #1's Medical Record, indicated there was no documentation to support nursing reassessed Resident #1 for placement of the WanderGuard bracelet, despite his/her continuous wandering behaviors and his/her episode of exit seeking on [DATE], to ensure his/her safety and decrease the risk of an elopement.<br><br>During an interview on [DATE] at 1:29 P.M., the Assistance Director of Nurses/Staff Development Coordinator(ADON/SDC) said Resident #1's Wandering/WanderGuard Assessment completed by Nursing Supervisor #1 on [DATE], indicated nursing should consider placement of a WanderGuard device on him/her. The ADON/SDC said that although, the check off box was marked and indicated that a WanderGuard was NOT placed on Resident #1, she said there was no documentation to support why the decision was made by Nursing Supervisor #1 not to.<br><br>The ADON/SDC said Resident #1's Admission status regarding his/her Wandering/WanderGuard Assessment (completed by Nursing Supervisor #1) and Resident Admission and Assessment (completed by Nurse #1), which had been completed on the same day, were answered differently.<br><br>The ADON/SDC said parts of Resident #1's Admission Assessments were left blank and no rationale was provided by either Nurse #1 or Nursing Supervisor #1 as to why they decided NOT to put a WanderGuard bracelet on him/her, even though he/she triggered for recommendation to use one.<br><br>During an interview on [DATE] at 9:57 A.M., the Director of Nurses (DON) said that upon Admission residents are screened for Fall Risk, Elopement, Wandering and WanderGuard Assessments.<br><br>The DON said she spoke with Nursing Supervisor #1, because there was conflicting documentation on Resident #1's Wandering/Wander Guard Assessment, dated [DATE] compared to Resident #1's Admission Assessment that was completed on the same day by Nurse #1.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The DON said if any of the questions are answered Yes on the Resident Admission and Assessment and or on the Wandering/WanderGuard Assessment the Nurse should apply a WanderGuard on the resident. The DON said a WanderGuard would be placed on a resident who has a history of elopement, does not want to be at the Facility, or exit seeks. The DON said at any time the Nurse can reassess a resident for elopement and place a WanderGuard on the resident to ensure safety, however Resident #1 was not reassessed. |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37330<br><br>Based on records reviewed and interviews for one of three sampled residents (Resident #1), who required the assistance of one staff member for ambulation, exhibited increased wandering and exit seeking with the need for frequent redirection by staff for safety, the Facility failed to ensure he/she was provided with the necessary level of staff assistance/supervision to prevent him/her from eloping and sustaining serious injuries.<br><br>On [DATE], at approximately 6:00 P.M., unbeknownst to staff, Resident #1 wandered off his/her unit, took the elevator to the main lobby, and although there was a Receptionist assigned to and seated in the Lobby, who was responsible for unlocking the main entrance door to let visitors and staff in/out, Resident #1 was able to exit through the main Lobby door, undetected and left the Facility. Resident #1 was ambulating outside alone for several minutes before being seen by staff, however before he/she could be safely redirected back into the Facility, Resident #1 fell forward landing face down on the pavement, was noted to be bleeding from lacerations on his/her head and nose, Emergency Medical Services (911) were activated, and he/she was transferred to the Hospital, where he/she was diagnosed with significant intracranial hemorrhaging (bleed in the brain) and died eight days later.<br><br>Findings include:<br><br>The Facility's Policy titled, Falls Prevention Policy and Procedure, dated ,d+[DATE], indicated it is Policy of the Facility to establish and maintain standard protocols to assess all Residents, utilizing Evidence Based Practice and Fall Risk Assessment tools to identify and document Resident risk factors for falls and establish a Resident-Centered Falls Prevention Plan based on relevant assessment information.<br><br>The Policy indicated the staff, with the support of the attending Physician, will evaluate functional and psychological factors that may increase fall risk, including ambulation, mobility, gait, balance, excessive motor activity, Activities of Daily Living (ADL) capabilities, activity tolerance, continence, and cognition. The Policy indicated the Staff will monitor and document each Resident's response to interventions intended to reduce falling or risks of falling.<br><br>The Facility's Policy titled, Elopement Risk Assessment & Prevention Policy and Procedure, dated , d+[DATE], indicated it is Policy of the Facility to establish and maintain standard protocols for the purpose of ensuring that each Resident residing in the Facility is appropriately assessed for risk of elopement, and utilizing an industry standard of practice Elopement Assessment Tool. The Policy indicated if an individual Resident is found at risk for elopement, appropriate interventions are implemented to decrease the potential for intentional or unintentional elopement from the Facility or campus premises.<br><br>The Policy indicated assessment intervals include upon moving into the Facility each Resident is assessed to establish a baseline and determine risk for elopement. The Policy indicated this is completed by the Admitting Nurse and then subsequently by the Minimum Data Set (MDS) Coordinator or the Licensed Team Member designated by the MDS Coordinator and this assessment will also be completed if there is a change in a Resident's wandering patterns.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The Policy indicated Residents which have the following are considered potentially at risk for elopement; Residents taking medications which potentially cause confusion or disorientation and Residents with indicators of Dementia.<br><br>The Policy indicated those Residents found to be at risk for elopement from the Facility or the campus will have a Wander Guard bracelet placed on one or more of the following areas: wrist, ankle, mobility device, such as a walker or wheelchair. Residents who are found at risk for elopement will have two (2) of their photos pulled or copied from their record and placed at the Facility's Receptionist desk in the Wander Guard Book.<br><br>Resident #1 was admitted to the Facility in [DATE], diagnoses included Left Cerebral Vascular Accident (stroke) with right hemiparesis (muscle weakness or partial paralysis on one side of the body), Altered Mental Status, Aphasia (a disorder that affects how one communicates), Type II Diabetes with long term use of Insulin, Atrial Fibrillation (irregular/rapid heart rate), Urinary Tract Infection, Hypothyroidism (thyroid gland does not produce enough thyroid hormone), Hypertension (High Blood Pressure), and Insomnia (persistent problem falling and staying asleep).<br><br>Resident #1's Admission Fall Risk Assessment, dated [DATE], indicated Resident #1 was assessed by Nursing as being at High Risk for falls, factors included intermittent confusion, history of falls, balance problems while standing and walking, decreased muscular coordination with required assistance (person and device), and prescribed medications that increase his/her risk to falls.<br><br>Resident #1's Admission Assessment, dated [DATE], also included a brief Wandering Assessment component, which indicated he/she was assessed by Nurse #1 for the need for placement of a WanderGuard bracelet device. The Assessment indicated that although Nurse #1 was directed to consider placing a WanderGuard on the Resident #1 because he/she was a new admission, but that Nurse #1 made the decision not to put a device on him/her.<br><br>Review of an additional more detailed Wandering/WanderGuard Assessment for Resident #1, dated [DATE], and completed by Nursing Supervisor #1, indicated she also assessed him/her for the need for placement of a WanderGuard device. The Assessment also directed Nursing Supervisor #1 to consider placing a WanderGuard on the Resident if Yes was the response to Any of the following:<br><br>- (a) new admission<br><br>- (b) able to walk independently<br><br>- (c) able to walk with walker or use wheelchair<br><br>- (d) able to walk with the assistance of others<br><br>- (e) Resident resistant to being placed in the Facility<br><br>- (f) Resident has history of wandering<br><br>- (g) he/she had been taking medications which cause confusion or disorientation<br><br>- (h) any indications of Dementia.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Further review of the Assessment indicated that although Nursing Supervisor #1 documented Yes as the response to 6 of the 8 indicators listed above, (a, b, c, d, g, h), the decision was made by Nursing NOT to place a WanderGuard on Resident #1. The Assessment also required Nursing Supervisor #1 to document Why if the device was not placed on the Resident, however that part of the Assessment was left blank and no rationale was provided by Nursing Supervisor #1.<br><br>Resident #1's Baseline Care Plan titled Falls, dated as initiated on [DATE], indicated Resident #1 was at risk of falling, had short/long term memory problems, was moderately cognitive impaired (stage of decline that affects short-term memory and the ability to complete complex tasks) and required one staff member assistance for transfers and mobility.<br><br>Review of Nurse #1's Progress Admission Note, dated [DATE], indicated Resident #1's gait was slow and weak, that he/she required a rolling walker, and one staff member assistance with transfers. The Note indicated Resident #1 needed frequent checks to prevent fall/injury due to Resident #1's confusion.<br><br>Review of Nurse's #1's Progress Note, dated [DATE], indicated Resident #1 was resistive to care, because of his/her impaired memory, he/she had an unsteady gait, was non-complainant with safety measures and Resident #1 required close supervision.<br><br>Review of Nurse's #1's Progress Note, dated [DATE], indicated Resident #1 remains at High Risk for Falls due to confusion and poor balance.<br><br>Review of Nurse's #2's Progress Note, dated [DATE], indicated Resident #1 continues to wander all evening, with standby assist and queuing required for safety.<br><br>Review of a Nursing Progress Note, dated [DATE], indicated Resident #1 continues wandering all night.<br><br>During an interview on [DATE] at 2:55 P.M., the Dietary Aide said she had observed Resident #1 always trying to get up, move, walk and said staff had to redirect him/her since he/she never wanted to stay in one place.<br><br>The Dietary said on [DATE], she had been asked by a nursing staff member (exact name unknown) to stay with Resident #1 since staff were busy and that she stayed with him/her approximately 30 minutes. The Dietary Aide said when she had sat with Resident #1, he/she had tried to get up several times and she had to redirect him/her to sit down for safety.<br><br>Review of a Therapy Treatment Encounter Note, dated [DATE], indicated Resident #1 was observed Wandering around the household (unit) attempting to open a staircase door, that he/she was looking for a specific room (not his/her room), was unable to understand due to confusion and mixing his/her words, Nursing aware.<br><br>(continued on next page) |

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| | 225281 | A. Building<br>B. Wing | 01/15/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Skilled Nursing Facility at North Hill (the) | 865 Central Avenue<br>Needham, MA 02492 |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on [DATE] at 2:27 P.M., (and during a follow-up interview on [DATE] at 11:04 A.M.) the Occupational Therapist Assistant (OTA) said on [DATE] she observed Resident #1 ambulatory with his/her walker, and that Resident #1 attempted to push open the door located on the far end of the unit. The OTA said she approached Resident #1 and distracted him/her from trying to exit the unit. The OTA said Resident #1 had a difficult time talking, verbalizing his/her needs and wants, was confused about his/her surroundings and had trouble following one step directions. The OTA said she had walked with and brought Resident #1 to the television room on the unit.<br><br>The OTA said she spoke with Resident #1's Nurse (exact name unknown) to let her know what had occurred and said the Nurse directed her to inform the Director of Nurses (DON). The OTA said that day she reported to the DON that she observed Resident #1 wandering on the unit and that he/she was attempting to exit the unit. The OTA said the DON informed her that she would start a Behavioral Log on Resident #1. The OTA said she documented in Resident #1's Therapy Note on [DATE] what she had observed and that she had reported the incident.<br><br>During a telephone interview on [DATE] at 12:19 P.M. Nurse #3 said that on [DATE] she was Resident #1's nurse, but said the OTA had not notified her (Nurse #3) that she (OTA) had observed Resident #1 exit seeking on the far end of the unit and had to intervene so he/she would not exit the door leading to the Facility's stairwell. Nurse #3 said she was not informed of Resident #1's behaviors by the OTA. Nurse #3 said the DON had not informed her of Resident #1's behaviors and she had not been aware that Behavioral Monitoring Sheet for Resident #1 had been initiated by the DON.<br><br>Review of Resident #1's Documentation of Resident Incapacity Pursuant to Massachusetts Health Care Proxy (HCP) Act, dated [DATE], indicated Resident #1's Physician determined Resident #1 lacked the capacity to make or communicate health care decisions, because of his/her cognitive impairment/stroke and his/her HCP was activated.<br><br>Review of a Nurse Progress Note, dated [DATE], indicated Resident #1 continues to wander all night, redirection done with no effect and he/she did not sleep.<br><br>During an interview on [DATE] at 3:49 P.M., Nurse #2 said Resident #1 was not aware of his/her surroundings, he/she would stand up without assistance and just wanted to walk around the unit. Nurse #2 said Unit staff would see Resident #1 get up and then would assist him/her to walk for his/her safety, since Resident #1 was a High risk for falls.<br><br>During a telephone interview on [DATE] at 11:23 A.M., Nurse #3 said she was informed that Resident #1 was not sleeping during the 11:00 P.M. to 7:00 A.M. (night) shift and he/she would wander all throughout the night.<br><br>During an interview on [DATE] at 5:14 P.M., the Director of Nurses (DON) said on [DATE], the OTA had safety concerns regarding Resident #1 getting up and walking alone, and that the OTA spoke to her about Resident #1's behavior. The DON said they were unable to place a WanderGuard on everyone that wanders on the unit because it would be considered a restraint, so she started a Behavioral Log regarding Resident #1's behaviors, to monitor them for three days. The DON said she was not informed by the OTA that Resident #1 had been observed exit seeking.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During a telephone interview on [DATE] at 2:22 P.M. Certified Nurse Aide (CNA), #1 said on [DATE], around 5:00 P.M., Resident #1 was sleeping in bed and was woken up by staff for dinner. CNA #1 said Resident #1 looked sleepy, was not making sense when he/she talked to him (CNA #1) so he had assisted Resident #1 to the dining room for dinner. CNA #1 said during dinner Resident #1 stood up from his/her seat and almost fell on to the resident who was sitting next to him/her, but CNA #2 was able to prevent the fall and redirect Resident #1. CNA #1 said shortly after, he left the dining room to help another resident. CNA #1 said he had not seen and was unaware Resident #1 had left the unit.<br><br>Review of CNA #1's Written Event Statement, dated as written on [DATE], indicated Resident #1 looked confused and had an unsteady gait. The Statement indicated that initially Resident #1 did not want to go to the dining room and that he (CNA #1) had last seen Resident #1 at approximately 5:30 P.M.<br><br>During an interview on [DATE] at 5:13 P.M., the CNA #2 said on [DATE] at the start of 3:00 P.M. to 11:00 P. M. (evening) shift, she was informed by staff that she needed to keep an eye on Resident #1 because he/she wandered. CNA #2 and said this was the first time she had cared for Resident #1. CNA #2 said during dinner Resident #1 was sitting at a table in the dining room when he/she had stood up, almost tipped over and she prevented him/her falling. CNA #2 said she tried to encourage and redirect Resident #1 to sit down, but he/she wanted to walk.<br><br>CNA #2 said she walked with Resident #1 twice around the unit. CNA #2 said Resident #1 was confused and was walking into other residents' rooms. CNA #2 said she told Nurse #2, that when she was walking with Resident #1 that he/she had almost fallen and that Nurse #2 told her (CNA #2) to keep an eye on Resident #1.<br><br>CNA #2 said at one point she had Resident #1 sit in the television room where a Dietary Aide was sitting after serving the dinner time meal. CNA #2 said it was that Dietary Aide's normal routine to stay in the television room and wait a little bit to allow residents time to finish their meals before going back to clear up dinner time meals plates etc, to bring them back to the kitchen. CNA #2 said during dinner time on the evening shift it really gets busy. CNA #2 said the Dietary Aide was [NAME] in the television room when she left the television room to go answer call lights, and that she left Resident #1 seated in a chair in the television room.<br><br>CNA #2 said although she had been instructed by Nurse #2 to keep an eye on Resident #1, that she did not ask the Dietary Aide to watch Resident #1 while she answered call lights.<br><br>During an interview on [DATE] at 3:49 P.M., Nurse #2 said Resident #1 was not alert to self or his/her surroundings, that his/her memory was impaired, he/she was at high risk of falls, and used a rolling walker for mobility. Nurse #2 said Resident #1 wanted to get up and walk, but was unaware of where he/she was going or what he/she was doing. Nurse #2 said Resident #1 needed a lot of verbal cueing and redirection from staff. Nurse #2 said staff needed to be with Resident #1 at all times when he/she was mobile for safety measures. Nurse #2 said on the 11:00 P.M. to 7:00 A.M. shift, Resident #1 would be up all night, was always restless and staff would take turns staying with Resident #1 to ensure he/she was safe.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Nurse #2 said on [DATE], during the evening shift, she was assigned to care for Resident #1, she observed him/her at the dinner table, and observed that he/she had almost fallen. Nurse #2 said she had to redirect Resident #1 to sit down and to eat. Nurse #2 said Resident #1 was seated and eating his/her meal when she left him/her with staff. Nurse #2 said she was unaware of when and how Resident #1 left the unit on [DATE].<br><br>During an interview on [DATE] at 2:55 P.M., the Dietary Aide said on [DATE], after serving the dinner time meals to the residents on Resident #1's unit, that she went into the television room to take a break and waited for the residents to finish their meals. The Dietary Aide said she saw CNA #2 walking around the unit with Resident #1 during dinner time and at one point they both walked into the television room. The Dietary aide said shortly after that, around 6:00 P.M. she left the television room, but does not recall if Resident #1 was in the television room alone at that time or if CNA #2 was still with him/her. The Dietary Aide said she had not been asked by CNA #2 to stay with Resident #1 or watch him/her.<br><br>Review of the Facility Incident Report, dated [DATE] at 5:45 P.M., indicated that Resident #1 was observed by CNA #2 standing up from the dining table had been unsteady on his/her feet. The Report indicated Resident #1 did not want to sit back down in his/her seat, therefore CNA #2 assisted Resident #1 and walked around the unit with him/her. The Report indicated CNA #2 escorted Resident #1 to the television room, where the Dietary Aide was located at the time. The Report indicated CNA #2 left the room to assist another resident and the Dietary Aide left the television room.<br><br>The Report indicated that at approximately at 6:09 P.M. Resident #1 exited the front door of the Facility and at 6:12 P.M. the Administrator and Director of Nurses (DON) observed Resident #1 outside, on the sidewalk in front of the building. The Report indicated that they observed Resident #1 placing his/her walker over the curb resulting in a witness fall. The Report indicated Resident #1 had sustained lacerations to the left side of his/her forehead and top of his/her nose. The Report indicated first aid had been provided and Resident #1 was sent to the Hospital.<br><br>Review of Resident #1's Hospital Admission Note, dated [DATE], indicated Resident #1 sustained a Petechial Hemorrhage (9 mm) within the known left temporoparietal infarct (a significant intracranial hemorrhage, brain bleed), left frontal scalp hematoma, and unchanged bilateral hypodense subdural collections, likely hygromas (fluid collection in the subdural space on both sides of the brain that appear low in density).<br><br>The Hospital Note indicated Resident #1 had been on Eliquis (anticoagulant, 5 milligrams two times a day) at the time of the fall, has significant intracranial hemorrhaging, with the potential for life-threatening progression or permanent disability and was transferred to another Hospital for further treatment.<br><br>During an interview on [DATE] at 9:27 A.M., Family Member #1 said Resident #1 died on [DATE] (eight days later) as a result of his/her injuries, sustained from the fall.<br><br>Review of the Facility's Surveillance Camera Video Footage, dated [DATE] and time stamped starting at 6:09 P.M., depicted the following:<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | -06:09:01.100 P.M. (View is from a camera was located at a high angle), you able to see part of the main Lobby entrance, there is a person sitting behind a computer at the Receptionist desk (camera view of individual is blurred). The Lobby door opens, and Resident #1 (as identified by the Administrator) can be seen ambulating with his/her rolling walker proceeding out through the main entrance doors at a quick pace. Resident #1 was not accompanied by anyone.<br><br>-06:09:11.568 P.M., Resident #1 can be seen walking through the second set of front Lobby doors, there was no one present in the video or outside the main Lobby entrance. Resident #1 starts to walk to the right side of the Facility, stops and then can be seen walking at a quick pace with his/her rolling walker to the left side of the Facility towards the direction of the Facility's Ambulance entrance.<br><br>-06:10:11.056 P.M. View of the Main Lobby entrance, doors are closed and doorway is empty<br><br>-06:10:12.530 P.M. View of the Main Lobby entrance, doors are closed and doorway is empty<br><br>-06:10:12.543 P.M. View of the Main Lobby entrance, doors are closed and doorway is empty<br><br>-Per the Video, approximately 40 seconds after Resident #1 was seen walking in the direction of the Ambulance entrance, can see in the video a person at the Receptionist Desk, with his/her arm reaching out towards the front door, the Administrator and DON can then be seen standing next to the Receptionist Desk heading towards the 1st set (inner set) of Lobby doors to leave the Facility.<br><br>-06:10:13.110 P.M. Resident #1 can be seen trying to get back into the Facility through the Ambulance entrance, Resident #1 hits his/her walker against the Ambulance door (which, per Administration was locked) and then Resident #1 reaches out with his/her arm jingling the door handle trying to get into the Facility. Resident #1 can then be seen turning around and walking out of the ambulance entrance.<br><br>-Per the Video (no time stamp noted) the Lobby door opens, and the Administrator and the DON are seen in the video walking out through the entrance way, This is 55 seconds (almost a full minute later) after Resident #1 had exited alone and undetected by the Receptionist, through the Facility's main entrance.<br><br>-The video continues to show the front Lobby, Emergency Medical Services Ambulance lights can be seen reflecting off the main lobby windows/entrance doors in the video, approximately 18 minutes after the Administrator and DON left the Facility's front Lobby entrance.<br><br>During an interview on [DATE] at 8:24 A.M., the Maintenance Director said the Receptionist controls the front door entrance by using a remote control device. The Maintenance Director said when the Receptionist presses the remote button and it will activate the doors to automatically unlock. The Maintenance Director said the person going out needs to be physically in range of the electronic eye (sensor system) to open the door to enter or exit the main entrance. The Maintenance Director said once the door is unlocked (can be opened) there is a delay of less than 10 seconds, during which it stays open prior to closing and relocking.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During a telephone interview on [DATE] at 2:23 P.M., the Receptionist said on [DATE], he was working the Receptionist desk from 3:00 P.M. to 11:00 P.M. The Receptionist said his responsibilities included opening the front Lobby door for visitors, residents and at times for staff by clicking a button on the handheld remote control The Receptionist said on [DATE], he recalled seeing the DON walking towards the front Lobby door, so he clicked the button to open the door for her. The Receptionist said he was working on the computer at that time, saw that the DON had not exited (after he clicked the button) the front Lobby door but had instead gone into the Administrator office, which was located behind the Receptionist desk.<br><br>The Receptionist said he did not see Resident #1 enter main Lobby, walk past him, or exit out the front door. The Receptionist said he was working on the Facility's computer, that there were a lot of people who went in and out of the Facility and that he could not recall if anyone was in the main Lobby when he initially unlocked the front Lobby door for the DON, when he thought she was leaving. The Receptionist said every time someone was at the Lobby door he would just click the button on the remote, the door would (unlocks) open, and people would come and go. The Receptionist said not everyone signed the Facility's Sign in book, when they arrived and/or exited the facility.<br><br>The Receptionist said a short time later the Administrator and the DON left the Facility together and he opened the front door for them. The Receptionist said the next thing he recalls was seeing the DON rush back into the Facility and the Administrator called him on the telephone, told him a resident had fallen and to let the Nurses know and where they were located. The Receptionist said when the Administrator and the DON came back into the Facility, that was when he was informed that Resident #1 gotten outside and had fallen outside.<br><br>Review of the Receptionist Witness Statement, dated [DATE], indicated he had not seen Resident #1 exit through the front door. The Statement indicated that although he could not remember, he believes he was on the computer when he saw the DON walk towards the front door, that he pushed the button to open the door for her, but the DON went towards the Administrators Office instead. The Statement indicated the Receptionist said he was working on the computer and he could not see over it.<br><br>During an interview on [DATE] at 12:48 P.M., the Director of Nurses (DON) said on [DATE] around 6:00 P.M. she was leaving the Facility, walked in front of the Receptionist desk to walk out of the Facility when she realized the Administrator was still in his office. The DON said instead of walking out of the Facility she went to the Administrators office, which is located behind the Receptionist desk to speak with him. The DON said then she and the Administrator walked out of the facility together.<br><br>The DON said she was speaking to the Administrator near their vehicles, the Administrator was facing the Facility and asked her if a resident was walking towards them. so she turned around to see who was walking down the hill, on the sidewalk. The DON said she walked closer to the individual and then saw that it was Resident #1. The DON said she then saw Resident #1 lift up his/her rolling walker to step off the sidewalk, that the walker became unbalanced and Resident #1 fell face forward down on the cement.<br><br>The DON said Resident #1 had turned him/herself over and she observed Resident #1's left forehead had a laceration and bleeding. The DON said Resident #1 was talking saying Look, Look. The DON said Resident #1 was licking his/her fingers and trying to wipe the blood on his/her forehead.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The DON said the Administrator called the Facility for help, the Nurse Supervisor came with dressing supplies, and she then ran to gather more supplies. The DON said upon returning to Resident #1, the Nurse Supervisor was helping Resident #1, 911 had been called, that EMS arrived quickly and Resident #1 was transferred to the Hospital.<br><br>The DON said she started an investigation and interviewed staff on his/her Unit after Resident #1 was transferred to the Hospital. The DON said CNA #2 told her she had walked Resident #1 around the unit and then she had him/her sit in the television room where a Dietary Aide was sitting. The DON said CNA #2 told her she left Resident #1 alone in the television room to answer a call light and that the Dietary Aide was still in the television room.<br><br>The DON said she was not sure how Resident #1 was able to make his/her way off the unit and down to the front Lobby main entrance. The DON said Resident #1 would not have not been able to use the stairs, must have used the elevator, that no alarms sounded in the Facility and he/she did not have a WanderGuard bracelet on him/herself, to trigger an alarm and alert staff.<br><br>The DON said she watched the Facility's Surveillance camera video footage and said she was able to identify Resident #1 in the Facility's main entrance and said Resident #1 exited the Facility through the front Lobby entrance, unescorted by anyone to the outside premises, heading to the sidewalk at the left of the Facility.<br><br>The DON said upon admission that Resident #1 was observed as being restless and was wandering the unit. The DON said the doors to Resident #1's unit were unlocked, that the elevators were located right outside his/her unit and residents were able to access the elevator without staff assistance. The DON said while she was in the Administrator office, most likely Resident #1 exited the elevator and was able to walk to and exit through the front door, since Resident #1's body triggered the door sensor to open because it had been already activated by the Receptionist pressing the button who had anticipated for her to leave.<br><br>The DON said her expectations was that for residents' that required assistance or were dependent on staff, that staff need to know the location of the resident, if the resident is in the common area or the television room, staff are required to be with the resident to watch them, to ensure that they were safe. The DON said if the staff member needs to leave the resident, the staff member must tell another Nursing staff member.<br><br>During an interview on [DATE] at 4:22 P.M., the Administrator said on [DATE], he was getting ready to go home when the DON came to his office and they left the Facility together. The Administrator said he was outside talking to the DON, he was facing the Facility, observed a person walking with a walker on the sidewalk, down the hill and questioned the DON if it was a resident. The Administrator said it was Resident #1, and as the DON approached Resident #1, he/she took a step off the sidewalk, fell . and he called Emergency Medical Services (911). |