STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335802	A. Building B. Wing	11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Arden Inc	46 Harriman Drive Goshen, NY 10924

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 - Minimal harm or potential for actual harm 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** 44673 Based on observation, record review, and interview conducted during the Recertification Survey and Abbreviated Survey NY00271654) from 11/8/2022-11/14/2022 for 1 of 2 residents (Resident #17) reviewed for elopement, the facility did not ensure all residents received adequate supervision and devices to prevent accidents. Specifically, the wanderguard system did not operate as designed to prevent Resident #17 with exit seeking behaviors from exiting the building during an ice storm. Findings are: The policy and procedure titled elopement dated 11/26/13 (no revision date) documented the facilities have written a program concerning missing residents' elopement prevention and elopement policy. Annual training of staff on code [NAME], as well as initial and ongoing assessment of residents concerning risk for wandering behavior and elopement. Resident #17 was admitted to the facility on [DATE] with diagnoses including Unspecified Dementia without Behavioral Disturbance, Chronic Obstructive Pulmonary Disease, and Paroxysmal Atrial Fibrillation. The 12/24/2020 Minimum Data Set (MDS a resident assessment tool) assessment documented the resident's cognition was severely impaired Brief Interview of Mental Status score (BIMS) of 5, Bed mobility limited assist and one-person physical assist. Transfer supervision and set up help only. Medical Doctor orders documented 2/16/2020 Wander guard bracelet to reduce risk of elopement, and check bracelet every shift for proper placement. Review of the incident report dated 2/15/2021 At 5PM Resident #17 was seen by Registered Nurse (RN#1) sleeping in the green recliner in the caring circle. 5:07PM trays came up from the dining room. Staff began giving out dinner trays and when they returned to the caring circle at 5:17PM the resident was out of the chair. The staff went to the resident room, and the resident was not there. RN#1 called a code [NAME] an immediate search of the entire floor was done unit 1 and unit 2 as well as the treatment room nursing station and physical therapy. During the search at 5:30PM the charge nurse was notified by the front desk in Independent Living that Resident #17 was with them. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 2/16/21 statement written by Maintenance staff documented at 11:30 AM on 2/15/21 they were made aware there was a problem with the end Health Care doors on unit 2. They went upstairs and noticed water leaking in through the maglock wanderguard. They tried to fix it but could not get it to work properly. They made sure the secondary alarm was working. They documented they went back a few times to continue to fix the maglock and at 3:30PM it was still not working. They documented they informed staff at both times that day, the maglock wanderguard was not working, but that the secondary alarm was working. The 10/2/2019 Care plan titled Wandering behavior Elopement Risk documented the following interventions heightened awareness during seasonal change, late afternoon hours and when visitors exit the facility, Apply Wander guard bracelet to wrist ankle and check for function and placement per policy, Door alarms Wander guard system on exit door and checked per policy. Review of the Certified Nursing Assistant care card dated 10/19 revised 11/03/2021 mental status oriented but confused at times, behavior type: exit seeking, monitor in caring circle, wanders: monitor doors in caring circle and end of hallway for alarms going off. Precautions maintain awareness of residents where about. Nursing Progress note dated 2/15/2021 Per 7-3 reports she was agitated in AM and exit seeking. Approximate 5:15PM this writer could not locate resident on unit other staff members notified per protocol and code [NAME] (missing Resident) protocol was implemented search of all rooms and storage arears on unit search at common arears, search of all rooms and storage arears on unit it did not reveal resident. At 530 pm as search was ongoing this writer received call from the front desk that resident was at the front desk having walked in through the front desk resident stated. I need to go home where is my mother this not my home complains feeling cold provided sweater blanket and escorted to unit Director of Nursing (DON) and administrator and director of maintenance notified. Son notified and assured of resident safety no injuries noted. The facility was unable to provide documentation that they implemented measures to reduce hazard risks and or implemented interventions consistent with the residents needs to eliminate the risk if possible and if not reduce the risk of accident. The facility was unable to provide documentation that the maglock wanderguard system was checked between 2/12/21-2/15/21. Review of the statement written on 2/16/2021 by Maintenance Mechanic On 2/15/2021 around 11:30AM the front desk informed me that there was a problem with the end health care doors on unit 2. The Maintenance Mechanic stated they went upstairs and noticed water leaking in through the Maglock wander guard. Maintenance Mechanic stated they tried to fix it but could not get the Maglock to work properly, so they made sure the secondary alarm was working, replaced the battery and tape holding it onto the door. Maintenance Mechanic stated they informed the staff that the secondary alarm was working. During an Observation on 11/8/2022 at 10AM Resident #17 had an alarm on the door to their room, when the door was knocked, the alarm went off staff responded Resident #17 was sitting in an arm chair. Resident #17 was wearing a wander Guard to the right wrist. During an Observation on 11/9/2022 at 1:00PM Resident #17 was on the unit having lunch in the common area. Wander guard in place on the right wrist. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the son of Resident #17 on 11/11/2022 at 2:47PM they stated they are happy with care provided to their mom. They stated they think the facility staff are doing their best with the resources they have. The son stated their mom is a challenge to try to keep safe. During an interview on 11/11/2022 at10PM with Registered Nurse (RN #1) they stated they remember the incident. RN #1 stated the resident was in the dayroom and when they went looking for the resident to medicate them, they could not find them. RN #1 stated they did a facility search, and while they were looking for the resident the clerk from the independent living called and ask they were missing a resident, RN #1 stated upon the resident return they did vital signs and notified the MD the DON and resident was placed on 15 min checks. RN #1 stated and order was obtained to have the alarm fixed. RN # 1 stated when they checked the video, they saw the resident had gone out the back between rooms [ROOM NUMBERS]. RN #1 stated the alarm did not work. During an interview with the Maintenance Mechanic, they stated they vaguely remember the incident. Maintenance Mechanic stated if the staff called and reported an alarm not working they would check the alarm and try to fix it, if unable they would notify their supervisor. Maintenance Mechanic stated every morning they check all the doors. During an interview on 11/10/2022 at 1:45PM with the DON they stated they remember the incident the resident went out of the side door during an ice storm. The DON stated water was dripping down and the alarm was not working. The DON stated the resident was wearing a wander guard. DON further stated Maintenance did fix the alarm. During an interview on 11/14/2022 at 10:45AM with the Administrator they stated they were not at the facility during the incident, The Admin stated they are familiar with the wander guard system. The Administrator stated if they were made aware the wander guard alarm was not working, they would have increased observation on that resident 5-15min checks along with any other residents with wander guards, they would bring staff in to monitor the door until the alarm was fixed and would ensure all doors with wander guard alarms were checked. 415.12(h)(1)