STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335338	A. Building B. Wing	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Rehabilitation and Nursing Center	918 James Street Syracuse, NY 13203

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** 34465 Based on observation, record review, and interview during the abbreviated survey (NY00283179) conducted on [DATE], the facility failed to ensure each resident received adequate supervision to prevent accidents for 1 of 3 residents reviewed. Specifically, on [DATE], a resident with a diagnosis of dementia and depression, and identified as a risk for elopement following exit seeking behaviors, was able to leave the facility undetected by staff through a third-story window, fell approximately 30 feet, and was found on the ground outside of the facility with fatal injuries. At approximately 10:00 PM on [DATE], the resident was noted to have barricaded themselves in their room when a nurse called to them to open the door. The resident opened the door very slightly and refused their medications. The door remained barricaded throughout the night and staff did not attempt to force the door open. Shortly after 5:00 AM on [DATE], a nurse went to the resident's door to bring their medications and could not open the door. The door was forcefully pushed open, and the resident was not found in the room. The window was open, and the resident was seen lying on the ground outside, approximately 30 feet below the window. The resident sustained traumatic injuries including multiple fractures and a head injury. The resident was transported via emergency medical services (EMS) to the hospital where they expired. This resulted in actual harm that was Immediate Jeopardy and Substandard Quality of Care to Resident #1 and placed 22 residents with wandering behaviors at risk for serious harm to resident health and safety. Findings include: The undated facility Wandering and Elopement Protocol documents: - the purpose of the protocol is to define the responsibilities and interventions of staff and visitors when a resident has been assessed as an Unsafe Wanderer or has a potential for Elopement. - Residents assessed as having a potential for unsafe wandering and/or elopement will be observed for exit seeking behavior, packing suitcases, bags, clothing, possessions, visual monitoring of exits or elevators, verbalization of a desire to leave, go home or how to leave the facility or a disregard for facility policy related to restricted areas, smoking policy, pass policy, etc. - Staff will document observations in the medical record and in the Wander Risk Assessment form. - The comprehensive care plan (CCP) will be adjusted as appropriate based upon assessment and with family input to address causative factors. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	- All members of the Interdisciplinary team are responsible to know the established plan of care and to report resident responses (positive and negative) as related to the plan of care. - The CCP will be based on the assessment and individualized to the resident and will include activities and interventions that are relevant to the resident's interests, backgrounds and exhibited behaviors. - Consideration for developing the CCP include to identify physical, social, or psychological driving forces that may enhance the resident's desire to wander such as pain, feelings of loss or abandonment, looking for family/pets etc., and evaluate environment for potential hazards for the resident. - Potential interventions include but are not limited to intermittent supervision, utilization of the Wanderguard Bracelet System, and frequent visual location checks. Policies were requested for resident safety checks and/or resident supervision and facility policies and procedures were not supplied. Resident #1 had diagnoses including dementia, Parkinson's disease, and depression. The [DATE] Minimum Data Set (MDS) assessment documented the resident's cognition was intact, they rejected care and wandered, and required supervision with activities of daily living (ADL). Wanderguard (bracelet to alert staff when a resident approached the elevator or exit doors) applied to resident The [DATE] physician's order documented the resident was to wear a wanderguard due to high risk for elopement. The [DATE] comprehensive care plan (CCP) documented the resident was a native Spanish speaker, preferred to speak Spanish, had limited physical mobility, history of aggressive behaviors including anger and ineffective coping skills, and was at risk for elopement related to wandering, attempting to leave the unit unattended, and wanting to go home. Interventions included the resident was dependent on staff for locomotion using a wheelchair, wanderguard was placed on the wheelchair, and staff were to distract the resident from wandering by offering diversions, activities, and food. The CCP documented staff were to check placement of the wanderguard every shift and were to monitor the resident's location. The frequency to monitor the resident's location was not documented on the CCP. The CCP was updated on [DATE] and documented the resident was independent with transfers, bed mobility and ambulation in room and corridor's and no longer used the assistive devices. The resident was independent with wheelchair mobility. Documentation of the resident's safety checks were requested and none were provided. The [DATE] at 10:31 AM, registered nurse (RN) Manager #10's progress note documented a stop sign was placed on the resident's door to stop other residents from entering room. Additionally, the resident had a sign on their door requesting the door to remain closed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The [DATE] Incident Report documented at approximately 11:00 AM, Resident #1 was seen between the double doors on the A South unit (different unit from where the resident resided) and these doors led to the outside. The resident was upset and stated they were leaving and going to Puerto Rico. The resident grabbed a large clothing rack that was in the hallway, appeared they were going to break the window, and continued to express a desire to go to Puerto Rico. The resident previously refused placement of a wanderguard on their leg so the wanderguard was placed on their wheelchair. After speaking with Spanish speaking staff that date, the resident agreed to the wanderguard being placed on their left ankle (wanderguard was applied to the wheelchair previously on [DATE]). The [DATE] at 1:02 PM RN Manager #10's progress note documented the resident required 24 hour a day supervision, had a wanderguard, and continued to express the desire to return home to their native country. A stop sign remained on their door as well as a sign to keep their door closed. The [DATE] at 9:28 PM, RN #12's progress note documented the resident was aggressive, threw medications, and could not be redirected. The resident was talking word salad (incoherent speech), was hallucinatory, and the plan was to check on the resident routinely. The [DATE] at 2:47 AM, licensed practical nurse (LPN) #2's medication administration note documented the resident's door was blocked when attempting to check pulse oximetry every four hours and vital signs every shift as ordered. The [DATE] at 5:11 AM, LPN #2's medication administration note documented the resident had a thing in their room in front of the door and the door could not be opened when they were attempting to give a morning medication. On [DATE] at 10:49 AM, the resident's room door was observed. The resident had a sign on the door to keep door closed that was written in both English and Spanish. The Director of Nursing (DON) stated in an interview at that time, the resident posted the sign on their door. During the observation, the Corporate [NAME] President demonstrated how they thought the resident used a wheelchair brake extender in place of the window crank to open the window. They stated no window crank was found in the room after the resident exited but the Corporate [NAME] President demonstrated how the wheelchair brake extender fit on the window (where the crank would go) and demonstrated opening the window. The window opened approximately 6 inches and stopped opening when it reached a silver screw that was in the window frame. The Corporate [NAME] President stated at that time, the resident had to apply a little bit of force to the window for it to move past the screw and the Corporate [NAME] President demonstrated this by applying a little force to the window. When this was done, the window opened up all the way and bypassed the screw that was in the window frame. The call bell box on the wall was cracked and damaged and there was no call bell cord attached to the box. The [DATE] at 11:19 AM, RN Supervisor (RNS) #9's progress note (entered in the medical record on [DATE] at 4:43 AM as a late entry) documented that RNS #9 was called by LPN #2 at 5:30 AM and was told the resident barricaded themselves in their room. RNS #9 relayed the information to RNS #8 (who was covering the resident's unit). A call was later received from RNS #8 who told RNS #9 the resident was gone and may have gone out the window. RNS #9 documented they immediately ran to the courtyard to find the resident lying on their back under a tree. The resident was conscious, responding to verbal stimuli, and that RNS #9 stayed with the resident while staff called 911. The [DATE] facility's investigation documented: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- The Resident #1 was alert and oriented and had poor safety awareness. - On [DATE] on the evening shift, the resident pulled the call bell from the wall twice and it was plugged back in. - LPN #3 attempted to give HS (hour of sleep) medications on [DATE] and the resident's door was barricaded. The resident was care planned for staff to reapproach if they had behaviors. When LPN #3 reapproached after some time, they were able to get the resident to open the door to visualize Resident #1. The resident refused their medications. - LPN #3 (evening shift) reported to the night shift LPN (LPN #2), the resident was behavioral and per the resident's care plan, was given time and reapproached. - LPN #2 was going to attempt vital signs and knowing the resident's behaviors and that the resident barricaded themselves in their room, documented they refused vital signs. The staff (the report did not specify which staff) reported it was normal for the resident to keep their door closed for privacy. - Staff did not hear any commotion in the resident's room through the night shift and the resident's call bell did not ring. - LPN #2 went to administer Synthroid (thyroid medication) at 5:11 AM on [DATE] and was unable to open the door. - LPN #2 notified RNS #8 and RNS #8 was able to push open the door. The resident was not in the room and the window was open. - Staff (report did not specify who) saw the resident on the ground outside and the resident was breathing and speaking Spanish. 911 arrived shortly afterwards. - Upon review of the room, the facility determined the resident had taken a wheelchair brake extender off their wheelchair and used it as a crank to open the window (the facility could not find the crank and could not determine if it fell out the window). The window had a restrictor on it to prevent the window from opening too far and it looked like enough force was applied to pass the limiter. The resident tied a cable wire and call bell together to create a rope and hung it out the window. The report documented the call bell adapter and unit in the room appeared to be broken from tampering by the resident. It was not in place, and it was not alarming which it should be. On [DATE] hospital report documented Resident #1 presented to the hospital after jumping from a window several stories high after barricading themselves in their room. The resident was found with a right leg tibia/fibula (lower leg bones below knee) open fracture (bone protruding through skin), comminuted (pulverized) T12 (thoracic spine) and L1 (lumbar spine) burst fracture, subdural hematoma (brain bleed), T11 and L2 fracture, pulmonary (lung) contusions, fractures of the coccyx (tailbone) and pubic rami (pubic bone) with retroperitoneal (behind the abdominal cavity) bleed and left leg displaced comminuted fracture of the mid to distal (lower portion) of the femur (thigh bone). The resident expired shortly after admission. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 1:45 PM, CNA #7 stated in a telephone interview, they worked the evening shift on [DATE] and was assigned to Resident #1. The resident had behaviors and could be aggressive. The resident was Spanish speaking, communication was difficult at times and there were Spanish speaking staff in the building to assist. CNA #7 stated during the evening shift on [DATE], the resident pulled the call bell out of the wall twice. The CNA stated they never knew the resident to do that before, and the resident's behavior was calm. At 10 PM, LPN #3 stated to CNA #7 that LPN #3 would do the last safety check on the resident because they were going to give them medications. CNA #7 stated LPN #3 found the resident's door barricaded but was able to get the resident to open it and saw the resident at the door. CNA #7 stated they recalled one other time the resident barricaded their door and did not recall if that was reported to anyone. On [DATE] at 12:33 PM, LPN #3 stated in a telephone interview, they worked the evening shift on [DATE]. The resident pulled the call bell out of the wall twice earlier in the shift and it was replaced and the resident was educated not to pull it out of the wall. The resident's medications were due at 6 PM, 9 PM, and 10 PM but LPN #3 stated they always gave the medications at once so the resident would not refuse. LPN #3 stated they tried to give the resident their medications around 10 PM on [DATE]. The resident always blocked their door so other residents could not enter and the resident would always come to the door and open it when LPN #3 knocked. On [DATE], the resident blocked the door and LPN #3 pushed the door open part of the way at around 10 PM. The resident came to the door and refused their medications and closed the door. LPN #3 stated their shift ended after 10 PM and they reported to LPN #2 the resident refused their medications and their door was blocked. LPN #3 stated they did not report this to a Supervisor in the past and did not report it to the Supervisor on [DATE]. On [DATE] at 1:18 PM and [DATE] at 11:22 AM, CNA #5 stated in telephone interviews, they worked [DATE] on the night shift and was assigned to Resident #1. LPN #2 reported to them the resident barricaded their door on the evening shift. During the start of CNA #5's shift, there was a lot going on including a fire alarm that took 45 minutes to deal with and then LPN #2 locked the medication room keys in the medication room. CNA #5 stated both RNS #8 and 9 were on the unit helping with the keys being locked in the medication room and CNA #5 did not see either RNS #8 or 9 check the resident's room. CNA #5 stated the CNAs were responsible to do safety checks on the residents 3 times a shift but they never did safety checks on the resident. CNA #5 stated they were told not to do the checks because the resident would become violent. CNA #5 stated they were told the nurse would check the resident when they gave medications. On [DATE] at 9:31 AM, LPN #2 stated in a telephone interview, they came on duty on [DATE] at 10:15 PM and worked the night shift, and: - when the shift started, LPN #3 (who worked the evening shift) reported Resident #1 barricaded themselves in their room and the Supervisor was aware. - LPN #2 did not notify the night Supervisor of the resident's door being barricaded because LPN #3 reported they already had. - LPN #2 thought it was strange when they did not hear anything further that night from the Supervisor but there were times when the Supervisor did not get back to them. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Certified nurse aides (CNA) were to check on residents every 2 hours during the night but they did not check on the resident because they were told by multiple Supervisors to leave the resident alone if they were not acting out at night. - LPN #2 stated the staff could not ensure the resident was safe when they did not check on them during the shift. - At 2:47 AM on [DATE], when LPN #2 entered a note the resident refused vital signs, and documented the resident's door was blocked and that the LPN did not attempt to get into the room at that time. - The first time LPN #2 checked on the resident on the night shift was around 5:10 AM on [DATE] when they went to give a morning medication and found the resident's door barricaded. - At 5:11 AM, LPN #2 notified RNS #8 the door was barricaded and RNS #8 responded within 5 minutes. RNS #8 pushed open the door and said the resident was missing. On [DATE] at 10:51 AM, RNS #9 stated in a telephone interview, they worked the night shift on [DATE] and was responsible for the 918 building and RNS #8 was responsible for staffing and the 906 building (the building where the resident resided). RNS #9 was in the office alone when LPN #2 called at around 5:30 AM on [DATE] and reported the resident's door was barricaded and had been all night. RNS #9 did not respond to the unit because they had their own work to do and when RNS #8 returned to the office from a unit about 10 minutes later, RNS #9 told RNS #8 about the phone call. RNS #8 stated to RNS #9 they were going to check the resident because they could have hurt themselves. RNS #8 left for the unit and then called RNS #9 stating the resident was not in their room and the window was open. RNS #9 ran to the courtyard where it was dark and pouring rain. A CNA was in the resident's window and spotted the resident on the ground on their back under a small tree. RNS #9 stated the resident was breathing and mumbling in Spanish and RNS #9 stayed with the resident until the ambulance arrived. RNS #9 stated they would have expected the night shift LPN to call them at the beginning of the shift so they could have checked the resident. RNS #9 stated that they and RNS #8 were on the unit during the shift and no one told them the resident was barricaded in their room. The resident put stuff in front of their door in the past and RNS #9 stated that they and RNS #9 stated they never told staff not to do safety checks on the resident and staff had to do safety checks to ensure residents were safe. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:14 AM, RNS #8 stated in a telephone interview, they started their shift as the evening Supervisor on [DATE] at 7:00 PM and worked until 7:00 AM on [DATE]. RNS #8 stated they were on the resident's unit frequently on the evening shift and LPN #3 never notified them the resident's door was barricaded. RNS #8 stated that they and RNS #9 were on the resident's unit from 1:30 AM to 3:00 AM assisting LPN #2 with an issue with the medication room keys and LPN #2 never told them the resident's door was barricaded. Between 5:00 AM and 5:30 AM on [DATE], RNS #8 stated they were in a COVID-19 positive resident's room and was not allowed to carry their cell phone in that room so when RNS #8 returned to the Supervisor's office, RNS #9 told them the resident had barricaded themselves in their room. RNS #8 stated they immediately went to the unit. RNS #8 pushed the resident's door open and found a wheelchair and bedside table behind the door. The resident was not in bed or the bathroom and they noticed the window open. RNS #8 called RNS #9 who went to the courtyard and found the resident. RNS #8 stated they had spoken to the resident's family member twice in the past and the family member never stated to RNS #8 that the resident said they would go out the window and RNS #8 had never heard the resident had barricaded their door in the past. RNS #8 stated safety checks were required to ensure a resident was not hurt or on the floor and they expected them to be completed. RNS #8 stated that they expected to be notified at the time the resident barricaded their door. On [DATE] at 5:03 PM, the resident's family member (who was the appointed health care proxy although the health care proxy was not activated as the resident was their own decision-maker) stated in a telephone interview the resident lived with them for 3 years and came to the facility when they could no longer care for the resident at home due to the resident's wandering. The family member stated one day the resident left and returned hours later and the family member told them they could not leave without anyone knowing. The family member reported after that it was a battle as the resident continued to leave unattended and one day, the resident fell in the road and a passerby called 911 and the resident went to the hospital. At the hospital, it was decided the resident could not live in the community anymore. The resident was very angry with them that they were put in the facility. The facility called the family member daily and reported behaviors and difficulty controlling the resident. The family member stated they told the staff the resident did not want to be at the facility and recalled a telephone conversation with staff a few months ago when they could hear the resident yelling in the background. The resident was yelling in Spanish I'm going to go out the window, watch me. The resident's family member told the staff exactly what the resident said and asked them to be sure the windows were locked. They did not recall who the staff were. On [DATE] at 11:47 AM, RN Manager #10 (Manager of the resident's unit) stated in a telephone interview: - safety checks were completed every 2 hours on all residents and staff knew to check residents with exit-seeking behavior more frequently though that was not necessarily in the CCP. - When a resident barricaded themselves in their room, RN #10 expected staff to notify the RN so an assessment could be completed and the provider could be notified. - The resident kept to themselves, stayed mostly in their private room, and had aggressive behaviors. When the resident refused care or medications, the CCP documented staff were to reapproach at a later time. - The resident's door was kept shut because the resident would get upset when other residents wandered in their room. Staff should do safety checks when the door was open or shut. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- The resident had a wanderguard applied to their wheelchair in ,d+[DATE] because they kept finding the resident at the elevators. The resident would not wear it on their body at that time. In ,d+[DATE], the resident was found on a different floor and was trying to exit to the outside and at that time, the resident agreed to wear a wanderguard on their ankle. - The resident regularly stated they wanted to leave the facility and return to Puerto Rico though RN #10 never heard that the resident threatened to go out the window. - RN #10 stated they were not aware the night shift staff were not completing safety checks when the resident was sleeping and that was not acceptable. - RN #10 stated they were not aware LPNs 2 or #3 did not report the resident barricading their door to the Supervisor at 10 PM and expected the LPN to notify the RNS immediately. On [DATE] at 12:43 PM, the attending physician stated in a telephone interview, the resident had dementia with behaviors, they were non-compliant and Spanish speaking. The resident was not very communicative and difficult to get information from. When the resident barricaded their door, it was a serious situation that needed to be addressed right away. The Administrator and Security should had been notified to determine what was going on because they could not be sure what the resident was doing behind the door. It was not acceptable that the staff on the night shift did not complete safety checks and that it was not acceptable when the Supervisor was not notified of the resident's barricaded door. On [DATE] at 10:33 AM, the Administrator stated in a telephone interview when a resident barricaded their door, they expected the RN to be called for an assessment and a plan to be implemented addressing the behavior. For a resident that barricaded themselves, they expected the RN and the physician to determine the appropriate interventions. The resident did not actually barricade their door using only a wheelchair placed behind it. If LPNs #2 or 3 were not able to access the door, then the situation should have been escalated so safety could be ensured. It was not normal to not round on a resident and residents were typically rounded on twice per shift. --- The Immediate Jeopardy was removed on [DATE] based upon the following: - All windows were audited to ensure they did not open further than 6 inches. - All residents with wandering behaviors were assessed to ensure all care planned interventions were in place. - All registered nurse (RN), licensed practical nurse (LPN), and certified nurse aide (CNA) staff were educated immediately on dangerous behaviors, including barricading of doors, the need for assessment by the RN and potential interventions including 1:1 staff. Education included when the RN did not respond to the initial call, staff would call the RN again, or follow the appropriate chain of command for notification. 10 NYCRR 415.12(h)(1)