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	01/19/2023

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 35045 Based on observation and interview during the abbreviated survey (NY00307502) the facility failed to provide a safe, comfortable, and homelike environment for 8 resident rooms (Rooms A10, A15, A17, A18, A19, A20, A21, A22 and A24) reviewed. Specifically, resident rooms A10, A15, A17, A18, A19, A20, A21, A22, and A24 had measured temperatures of 51.8-71 degrees Fahrenheit (F), below acceptable/comfortable temperature ranges of 71-81 degrees F, snow was observed inside the resident room windows, and frozen blankets and soaker pads lined the bottom windowsill where the snow and wind entered the residents' rooms. Findings include: The facility policy Baseline Room Temperature Protocol dated 2017, documented comfortable and safe temperature levels meant that the ambient temperature should be in a relatively narrow range that minimizes residents' susceptibility to loss of body heat and risk of hypothermia or susceptibility to respiratory ailments and colds. The facility must maintain safe and comfortable temperature levels. The temperature in facility rooms would be maintained at a temperature range between 71 degrees to 81 degrees. Temperatures would be measured as needed during environmental rounds and when there was a complaint, via the air temperature above floor level in resident rooms, dining areas, and common areas. Any discrepancy or complaint of hot or cold, would be reported to the supervisor and then to maintenance/administrator to be reviewed and addressed. During an interview on 12/24/22 at 11:45 AM, maintenance technician #3 stated they were aware some of the rooms were cold and the boiler had been tripping off during the night and needed to be reset every 2 hours. During an interview on 12/24/22 at 11:55 AM, the Director of Social Work stated they were the assigned manager on duty and was not aware of any resident complaints of cold rooms on Unit A. They stated they had been doing routine rounding on Unit C where there were some complaints of cold rooms and they had not notified maintenance. During observations on 12/24/22 from 12:04 PM to 12:15 PM, maintenance technician #3 measured the resident room temperatures on Unit A. The room temperatures were measured at the floor level to the wall at headboard level. The Director of Social work was also in attendance. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Room A15 - 53.6 degrees F, the heating unit was set at 85 degrees F, and the resident said they were freezing. - Room A17 - 60 degrees F, the heating unit was set at 78 degrees F. - Room A18 - 57.3 degrees F, the window glass appeared to be cracked on the right bottom corner and there was snow built up in between the screen and the glass window. There was snow on the windowsill of the resident's room and there was a frozen blanket and a soaker pad covered with snow tucked in the corner. The heating unit was set at 75 degrees F. The resident stated they were freezing and going to get sick. They stated they had been complaining to nursing staff of cold room temperatures for 4 months. - Room A19 - 57 degrees F, the heating unit was set at 79 degrees F. The windowsill had snow on the left corner around the resident's family pictures. The resident was observed with covers up to their neck and said they were freezing. Maintenance technician #3 turned the heating unit up to 90 degrees F. - Room A20 - 51.8 degrees F, the heating unit was set at 87 degrees F. - Room A21 - 61 degrees F, the heating unit was set at 76 degrees F. The window had visible snow built up in the corner. - Room A22 - 61 degrees F, the heating unit was set at 78 degrees F. During observations on 12/24/22 from 12:15 PM to 12:50 PM, maintenance technician #4 measured room temperatures on Units A and C. - Room A24 was 71 degrees F. The heating unit was set at 90 degrees F. There was visible snow in the screen on the interior of the window. - Room A10 was 56 degrees F. The heating unit was set at 80 degrees F. The resident said their room was freezing and the windowsill was so cold when they put their glasses on in the morning, they felt cold on their face. There was visible snow in the window with a blanket on the windowsill over the snow. During the room temperature monitoring maintenance technician #4 stated they had not done room temperature monitoring rounds on Unit A and they were due sometime in the middle of next week. They stated the buildings windows were old and drafty, and the residents should turn their heaters up in their room and keep the doors closed to keep the rooms warmer. During an interview on 12/24/22 at 12:55 PM, the Assistant Director of Nursing (ADON) stated they were not aware of complaints of cold room temperatures. The ADON stated they wanted to retake the room temperatures because the Director of Social Work had told them maintenance staff #3 was aiming the thermometer at the room floor and not the wall where the head of the bed was located. The ADON was observed while they remeasured the following resident room temperatures at the wall where the head of the bed was located at approximately 1:08 PM: - Room A10 was 61.8 degrees F. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Room A15 was 60.2 degrees F. - Room A17 was 65.1 degrees F. - Room A18 was 64.9 degrees F. - Room A19 was 65.1 degrees F. - Room A20 was 65.8 degrees F. - Room A21 was 64.7 degrees F. - Room A22 was 72.5 degrees F. During interview with the Assistant Administrator on 12/24/22 at approximately 1:15pm, they stated the Administrator was unavailable and they were covering the administrative duties. They became aware of the cold room temperatures from the Director of Social Worker who informed them earlier. They were unaware of the number of rooms with cold temperatures but stated staff were in the process of doing room temperature checks. 10 NYCRR 415.29(j)(1)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33420 Based on observations, record review and interview during the abbreviated survey (NY00308045), the facility failed to ensure that all alleged violations involving abuse and neglect were reported to The New York State Department of Health (NYSDOH) as required for 1 of 5 residents reviewed (Resident #92). Specifically, Resident #92 eloped from the facility on 12/28/22, and it was not reported to the NYSDOH as required. Findings include: The facility policy Elopement Prevention revised 2/2020 documented the facility maintained a process to assess all residents at risk for elopement and implemented prevention strategies for those identified as elopement risk. Elopement was defined as a cognitively impaired resident's ability to move about inside the facility aimlessly and without an appreciation of personal safety needs and who may enter a dangerous situation. The NYSDOH Nursing Home Incident Reporting Manual dated 8/2016 documented at least one of the following elements must be present for an elopement incident to be reportable to the NYSDOH: - Resident with cognitive impairment or elopement risk leaves the facility undetected. - Resident, despite cognition, is at risk for elopement and remains missing after search of the building is conducted. - Resident with a pass fails to return from an outing. Resident #92 had diagnoses including Epileptic syndrome (seizures), Parkinson's disease (a progressive neurological disorder), neurocognitive disorder with Lewy bodies (dementia), attention and concentration deficits, and visual and auditory hallucinations. The 12/13/22 Minimum Data Set (MDS) assessment documented the resident had moderate cognitive impairment, had moderately severe depression, wandered 1-3 of 7 days, required limited assistance of one for walking in their room and the corridor, extensive assistance of one for locomotion on and off the unit, was not steady during walking but was able to stabilize without human assistance, used a walker and a wheelchair, and used a wander elopement alarm daily. The impact of wandering section of the MDS was not completed. The comprehensive care plan (CCP) initiated 4/29/22 documented the resident was at risk for elopement due to exit seeking and wandering behaviors. The Elopement risk assessment dated [DATE] completed by licensed practical nurse (LPN) #28 documented Resident #92 propelled themself with some assistance, no attempts or history of elopement, was homeless prior to admission, wandered aimlessly, looked for spouse/loved ones, and had major psychiatric or cognitive impairment diagnosis. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The undated facility Full QA Report (Accident/Incident Report) documented an elopement was reported on 12/28/22 at 6:00 PM by Assistant Director of Nursing (ADON) #2. Resident #92 left the facility and was off the premises. The assigned care giver was certified nurse aide (CNA) #3, there were no witnesses, the resident was oriented to person, place, and time, and had a wander alert device. The resident was last observed at 6:00 PM by CNA #3. The resident was located at their home residence by the resident's family member. There was no wander alert device in place. The elopement details included: - the resident's wander alert device was last checked for functioning and placement at 4:00 PM, - the resident was last seen at 5:00 PM taking a shower, - the resident was noticed missing at 6:00 PM - the resident was located at 7:30 PM and returned to the facility. No injuries were noted. Actions included the call bell was in reach with instruction, family was called to assist with behaviors, the immediate supervisor was notified, the CCP was updated, outside services were required, a skin assessment was completed, and the resident was assessed head to toe with no injuries, 1:1 supervision was in place and a wander alert device was placed on the resident. The investigative conclusion documented Resident #92 ambulated independently with a walker. On 12/18/22 (wrong date documented) at approximately 6:00 PM, the resident exited the facility without obtaining a pass or stopping at the front desk. Staff notified the supervisor when the resident was not present for dinner. The facility was searched, and the resident was not present. Police were notified and family was contacted. The resident was located at their former home and was returned to the facility. Upon return the resident was assessed for injury and none noted. Upon interview the resident stated they went home to visit their spouse and child. The resident stated they were unaware of the pass policy and did not know one was needed. The resident was reeducated on the process and a wander alert device was placed. There was no documentation the incident was reported to NYSDOH as required. On 1/19/23 at 9:18 AM attending physician #41 was interviewed via phone and stated the resident had Lewy body dementia, was very sick, unreliable and their brain was not good. The resident was at high risk for elopement, and they were aware Resident #92 expressed a desire to leave the facility. During a telephone interview on 1/19/23 at 10:44 AM the DON stated reportable incidents included abuse, injuries of unknown origin, and elopements and they referred to the reporting manual for guidance. Suspected abuse, neglect, and mistreatment or elopements had to be reported to NYSDOH within 2 hours. Resident #92 was alert and oriented, had a BIMS (Brief Interview for Mental Status) of 12 (moderately impaired cognition) and did not have a dementia diagnosis. On 12/28/22 Resident #92 did exit the facility. An investigation was completed, and they concluded Resident #92 exited the facility with the intention to go home. The resident was not wearing a wander alert device, the alarms did not sound, and staff let the resident exit the building. The resident was located at their home address, and they were brought back to the facility by police. The DON stated they determined after looking at the incident reporting manual, due to the resident being alert and oriented without impaired cognition, it was not an elopement and that was why they did not report the incident to NYSDOH. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/19/23 at 1:21 PM The Administrator stated during a phone interview, reportable incidents were incidents that met the standards according to the reporting guidelines. Reportable incident's included choking, falls with injuries, a care plan violation of abuse, and in certain circumstances elopements were reportable. The Administrator defined elopement as someone without capacity, that could not make safe decisions with regards to their safety, that wandered out of the facility. Resident #92 had a BIMS score of 12, was able to make decisions, and the BIMS score was mild impairment. The Administrator stated they did not have direct oversight of the facility investigation. The DON had direct oversight of this investigation. At first, they did not consider Resident #92's incident an elopement. After reviewing the police report the incident could be considered an elopement depending on how someone determines the police report, and this could have been reportable incident. A facility incident/ accident report should be completed within 5 days and if determined a reportable incident it should be reported within 2 hours for abuse issues, and everything else should be reported within 24 hours. With Resident #92 the investigation should have been completed within 5 days. 10NYCRR 415.4 (b)(2)(3)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33420 Based on interview and record review conducted during the abbreviated survey (NY00308045), the facility failed to ensure all alleged violations involving abuse, neglect, or mistreatment were thoroughly investigated for 1 of 5 residents (Resident #92) reviewed. Specifically, Resident #92 eloped from the facility on 12/28/22, there was no documented evidence the investigation was completed timely or thoroughly, and the facility did not conclude the resident eloped from the facility after being found by law enforcement wandering on a 4 lane highway approximately 4 miles from the facility. Findings include: The facility policy Accident /Incident dated 8/2019 documented the facility was to monitor and evaluate all occurrences of accident/incidents or adverse events occurring on the facility premises. The occurrences must be evaluated and investigated. Any unwitnessed incident or accident must be investigated for potential abuse, neglect, mistreatment, or injury of unknown origin. Resident #92 had diagnoses including epileptic syndrome (seizures), Parkinson's disease (a progressive neurological disorder), neurocognitive disorder with Lewy bodies (dementia), attention and concentration deficits, and visual and auditory hallucinations. The 12/13/22 Minimum Data Set (MDS) assessment documented the resident had moderate cognitive impairment, had moderately severe depression, wandered 1-3 of 7 days, required limited assistance of one for walking in their room and the corridor, extensive assistance of one for locomotion on and off the unit, was not steady during walking but was able to stabilize without human assistance, used a walker and a wheelchair, and used a wander elopement alarm daily. The impact of wandering section of the MDS was not completed. The comprehensive care plan (CCP) initiated on 4/29/2022 documented the resident was at risk for elopement due to exit seeking and wandering behaviors. The Elopement risk assessment dated [DATE] completed by licensed practical nurse (LPN) #28 documented Resident #92 propelled themself with some assistance, no attempts or history of elopement, was homeless prior to admission, wandered aimlessly, looked for spouse/loved ones, and had major psychiatric or cognitive impairment diagnosis. The facility Full Quality Assurance (QA) report (incident/accident report) dated 12/28/22 at 6:00 PM by registered nurse (RN)/Assistant Director of Nursing #2 documented Resident #92 eloped from the facility. There were no witnesses, the resident was oriented to person, place, and time, had a wander alert device and no actions were documented. The resident was last observed at 6:00 PM by certified nurse aide (CNA) #3 and was located at their home residence by the resident's child. The facility investigation documented the timed events as: -Resident #92's wander alert device was last checked at 4:00 PM, -Resident #92 was last seen at 5:00 PM taking a shower, -Resident #92 was found to be missing at 6:00 PM (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #92 was located at 7:30 PM and returned to the facility. Statements included in the facility investigation documented: -Licensed practical nurse (LPN) #39 provided a statement on 12/28/22 at 6:57 PM, they last observed Resident #92 in their room, on their bed around 3:45 PM. The statement time was before the documented time the resident returned to the facility. -CNA #3 provided a statement on 12/28/22 at 6:45 PM, they saw Resident #92 around 3:30 PM, going to the bathroom with clothes in their hands. That was the last time they saw the resident. The statement time was before the documented time the resident returned to the facility. -CNA #1 provided a statement on 12/28/22 at 6:57 PM they last saw Resident #92 standing outside the room in a gray coat and baseball cap around 4:00 PM - 4:30 PM. The statement time was before the documented time the resident returned to the facility. -CNA #8 provided a statement on 1/4/23 at 2:43 PM they had been working at the front desk in the lobby, they were not aware the resident got out the door. The facility actions documented there were no injuries noted, the call bell was in reach, family was called to assist with behaviors, the immediate supervisor was notified, the CCP was updated, outside services were required, a skin assessment was completed, and the resident was assessed head to toe. Vital signs (VS) were stable, the resident had 1:1 supervision, and a wander alert device after they returned. The undated and untimed facility investigation summary by the Director of Nursing (DON) documented the conclusion of the investigation was Resident #92 ambulated independently with a walker. On 12/18/22 (incorrect date) at approximately 6:00 PM, Resident #92 exited the facility without obtaining a pass or stopping at the front desk. Staff notified the supervisor when the resident was not present for dinner. The facility was searched, and the resident was not present in the facility. The police and family were contacted. The police located Resident #92 at their former home and Resident #92 was returned to the facility. Upon return a registered nurse (RN) assessment was completed and no injuries were noted. Upon interview Resident #92 stated they went home to visit their spouse and child; they were unaware of the pass policy and did not know one was needed. The resident was reeducated on the process and a wander alert device was placed. On 1/17/23 a copy of an additional statement from business office manager #38 was provided through the secured file transfer. The statement was undated and untimed and documented on 12/28/22 at approximately 4:50 PM they spoke to Resident #92 in front of the first floor elevator, outside the Administration suite, approximately 30 feet from the side entrance of the building. Resident #92 asked why no one could come through the side doors. Business Office Manager #38 explained the side doors were not for residents or guests to enter or exit. The resident asked how people got into the building and Business Office Manager #38 told the resident people go through the front door to make sure everyone was screened when entering, and to make sure appropriate people were entering and exiting the building for the safety of the employees and residents. The resident asked Business Office Manager #38 if they could get money at the front desk, and they told the resident they could request funds if they had some. The resident thanked them and headed toward the front door. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documentation how the resident was able to leave the facility undetected, where the wander alert device was that was documented as in place at 4:00 PM, or if the facility identified the residents CCP was not followed by CNA #3. The additional statement by Business Office Manager #38 was obtained on 1/6/23 after the facility concluded their investigation on 1/4/23. There was no statement included from ADON #2 who said they had provided a statement. The facility did not rule out abuse, neglect, or mistreatment in the conclusion of the investigation. On 1/5/23 at 4:30 PM ADON #2 stated during an interview, the elopement process included staff were to report when a resident was missing, and a Code Yellow (missing resident) was called overhead. On 12/28/22 CNA #3 notified ADON #2 around 6:00 PM Resident #92 was missing and they were unable to find the resident. The resident was last seen going down the hallway to take a shower before dinner. They stated they did not know when or where the resident was last seen. They announced a Code Yellow 3 times on the overhead page, printed and passed out pictures of the resident, and all staff searched for the resident. The resident was not found, and they called the DON at 6:13 PM. They completed a written statement which documented what they did and gave the statement to the DON on 12/28/2022. The facility incident report was initiated by them, they obtained statements from the staff on the unit, and documented on the investigation form. ADON #2 stated they did not complete the conclusion and the DON did that. There was no documentation to support a Code Yellow was called at the time the resident was reported missing. On 1/18/23 at 10:04 CNA #3 stated during a phone interview they were familiar with Resident #92. The resident did have confusion and at times was able to remember the staff to an extent. The resident was at risk for elopement and staff were to keep an eye on him (was unable to state what that was) as the resident was very fast. On 12/28/2022 the resident did have a wander alert device on their ankle at 3:30 PM after finishing their shower. The residents CPP plan documented the resident required one assist for ambulation, staff tried to follow the CCP however the resident did [their] own thing. In the past the resident expressed a desire to leave, and they notified the supervisor. On the day of the incident the resident did not express they wanted to leave. The CNA stated the resident used to say they wanted to go home to their spouse and asked why they could not go home. Staff would redirect the resident. The CNA did not recall the last time the resident was exit seeking or said they wanted to leave. CNA #3 provided care to Resident #92 on the night they eloped. They went to check on the resident around 5:30 PM and could not find them. They looked until 5:45 PM and then called a Code Yellow (missing resident) with the resident's name and room number. On 1/18/2023 at 10:34 AM CNA #8 stated during a phone interview they covered the front desk as a receptionist a couple days per week. If the resident did not have a bracelet there would be no way to identify a wanderer and they were not aware of a picture book that included residents at risk for elopement located at the front lobby desk. CNA #8 stated they were not familiar with Resident #92 and did not know the resident was at risk for wandering. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 1/18/2023 at 10:53 AM Business Office Manager #38 stated on the day of the elopement they saw Resident #92 at the elevators on the first floor approximately 30 feet from the side door entrance. They did not recall the time. The resident asked them why people were not able to come and go at the side door. Business Office Manager #38 explained it was for emergency purposes and if people wanted to leave, they would have to come and go at the front entrance. They did not know the resident and did not know the resident was at risk for elopement. They stated they looked at the resident's wrist and did not see a wander alert device and no alarms were going off. During a phone interview on 1/19/23 at 10:44 AM the DON stated reportable incidents included abuse, injuries of unknown origin, and elopements and they referred to the reporting manual for guidance. Suspected abuse, neglect, mistreatment, and elopements had to be reported to DOH within 2 hours. Resident #92 was alert and oriented, had a BIMS (Brief Interview for Mental Status) of 12 (moderate cognitive impairment) and did not have a dementia diagnosis. The DON stated staff reported the resident expressed wanting to go home to be with their spouse on occasions, however nothing was directly reported to them about the resident having exit seeking behaviors or expressing a desire to leave. The DON stated to their knowledge the resident did not attempt to elope before 12/28/22 and they were not aware the resident had previously left Unit 3 and went to the A building to get soda. On 12/28/22 Resident #92 did exit the facility. ADON #2 completed the investigation and the DON thought they completed the conclusion on 1/4/23. They concluded Resident #92 exited the facility with the intention to go home. The resident was not wearing a wander alert device, the alarms did not sound, and staff let the resident exit the building. The resident was located at their home address, and they were brought back to the facility by police. The DON stated they determined after looking at the incident reporting manual, due to the resident being alert and oriented without impaired cognition, this was not an elopement and that was why they did not report the incident to New York State Department of Health. The DON stated Business Office Manager #38 submitted their statement on 1/6/23. The DON thought ADON #2's statement was in the facility investigation that was sent to the DOH. During a phone interview on 1/19/23 at 1:21 PM the Administrator stated reportable incidents were those that met the standards according to the reportable guidelines. Reportable incident's included choking, falls with injuries, a care plan violation of abuse, and in certain circumstances elopements were reportable. The Administrator defined elopement as someone without capacity and could not make safe decisions without regards to their safety, who wandered out of the facility. Resident #92 had a BIMS score of 12 which was mild impairment and was able to make decisions. The Administrator stated they did not have direct oversight of facility investigations. At first, they did not consider Resident #92's incident an elopement but after reviewing the police report the incident could be considered an elopement depending on how someone interprets the police report. A facility incident/ accident report should be completed within 5 days and if determined to be a reportable incident it should be reported within 2 hours for abuse issues, and all other incidents should be reported within 24 hours. The investigation for Resident #92's incident on 12/28/22 should have been completed within 5 days. 10NYCRR 415.4(b)

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Bishop Rehabilitation and Nursing Center	918 James Street Syracuse, NY 13203

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 33420 Based on record review, observation, and interview during the abbreviated survey (NY00308045), the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs for 1 of 5 residents reviewed. (Resident #92). Specifically, the resident's comprehensive care plan (CCP) for elopement was not revised after the resident was found wandering, exit seeking and verbalizing they wanted to leave the facility. Resident #92 eloped from the facility undetected on 12/28/22 and the CCP was not revised until 1/8/2023. Findings include: Resident #92 had diagnoses including Epileptic syndrome (seizures), Parkinson's disease (a degenerative neurological disorder), neurocognitive disorder with Lewy bodies (a form of dementia), attention and concentration deficits, and visual and auditory hallucinations. The 12/13/22 Minimum Data Set (MDS) assessment documented the resident had moderate cognitive impairment, had moderately severe depression, wandered 1-3 of 7 days, required limited assistance of one for walking in their room and the corridor, extensive assistance of one for locomotion on and off the unit, was not steady during walking but was able to stabilize without human assistance, and used a wander alert device daily. The impact of wandering section of the MDS was not completed. The comprehensive care plan (CCP) initiated 4/29/2022, documented the resident exhibited potential risk for elopement due to cognitive impairment/decline and wandering behavior. Interventions included to distract the resident by offering pleasant diversions, provide a wander alert device, and check wander alert device placement every shift. The site of the wander alert device was not included. The elopement risk evaluation dated 5/19/2022 completed by registered nurse (RN) #26 documented the resident was fully ambulatory, wandered aimlessly, was content with placement, had made one or more attempts to elope, and behavior was redirected. Elopement interventions included a wander alert device. The elopement risk evaluation dated 9/6/22 completed by licensed practical nurse (LPN) #28 documented the resident propelled themself with some assistance, had made no attempts to elope, was homeless prior to admission or unable to comprehend out-on-pass protocol, wandered aimlessly, looked for spouse/loved ones and was redirectable, and had a major psychiatric or cognitive impairment diagnosis on record, but no history of exit seeking or elopement attempts. Elopement interventions included wander alert device, identify triggers for wandering, document behaviors and attempt to identify a pattern to target interventions, and distract resident from wandering by offering pleasant diversions. There was no documentation the CCP was reviewed or revised with interventions including identifying triggers for wandering, documenting behaviors, and attempting to identify a pattern to target interventions, and distracting the resident from wandering by offering pleasant diversions. A physician order dated 11/10/22 documented monitor for wandering, packing belongings, exit seeking behaviors, and verbalizing desire to leave. Document in progress notes every shift for monitor. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documentation the CCP was revised to include physician ordered monitoring of wandering, packing belongings, exit seeking behaviors, and verbalizing desire to leave. Nursing notes documented the following: - on 11/10/2022 at 1:02 PM by LPN #28 the resident was at low risk for elopement. - on 11/17/2022 at 8:47 PM by LPN #31 the resident wandered to unit A South looking for soda (a separate building connected by an enclosed bridge). The wander alert device was checked for placement. - on 12/2/2022 at 1:32 AM by LPN #33 the resident had behaviors, was fully dressed in a coat on at 11:30 PM sitting in the chair next to the bed with a wander alert device on their wrist. The LPN redirected the resident, assisted with changing them into pajamas and assisted them to bed. The resident was asleep at that time, and they would continue to monitor. - on 12/8/2022 at 5:46 PM by LPN #34 the resident walked over to 3 North asking staff how to get out of the building. The nurse checked the resident's wander alert device and directed them back to 3 South and the redirection was successful. - on 12/8/2022 at 6:32 PM by LPN #31 the resident was exit seeking most of the evening, wanting to get down the elevator to catch a bus. Their wander alert device was in place and medications were given as ordered. The resident was redirected many times. - on 12/9/2022 PM by LPN #31 the resident was wandering around the unit without their walker, had difficulty standing and a certified nursing assistant (CNA) put them in a wheelchair. The resident got themself up and went to bed. Shortly after the resident was found wandering in the hall without the walker. The resident had to be redirected many times that evening. The resident was safely in bed and the nurse was at the table right outside the room and would let the oncoming shift know of the behaviors. - on 12/10/2022 PM at 5:11 AM by LPN #35 the resident slept very little, was seeking to escape, and wandering with some confusion. - on 12/15/2022 at 12:50 PM by LPN #27 the resident verbalized to staff which door do I use to get out of here?. The resident was redirected by staff several times with distraction techniques, i.e., coffee, etc. with negative results. The resident continued to ambulate around the floor with and without the walker. - on 12/27/2022 at 5:38 PM by LPN #7 the resident required to be redirected multiple times that shift. Their wander alert device was in place. There was no documentation the CCP was reviewed or revised to include interventions and monitoring of the resident after increased wandering and exit seeking behaviors. On 12/28/2022 the resident eloped from the facility and was found approximately 4 miles from the facility by the police. There was no documentation in the nursing notes the resident eloped from the facility. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility full QA report dated 12/28/2022 at 6:00 PM by RN #2 documented the resident left the facility eloping from the facility. No injuries were noted, the call bell was in reach with instruction, family was called to assist with behaviors, the immediate supervisor was notified, the CCP was updated, outside services were required, a skin assessment was completed, and the resident was assessed head to toe. The nursing notes from 12/28/22-12/29/22 documented 1:1 was in place. The risk for elopement CCP with a goal of the resident's safety would be maintained through the review date was initiated on 1/4/23. The CCP documented on 12/28/22 the resident exited the facility and went to their former residence/home of spouse. The CCP revisions included: - created by LPN #28 on 1/4/23, the resident had elopement behavior symptoms. - created by LPN #28 on 1/5/23, the resident was on hourly monitoring rounding. - created by the DON on 1/8/23, on 12/29/22 the resident's room was changed - created by the DON on 1/8/23, the resident was placed on 1:1 (supervision) upon return until 12/29/22. During an interview with CNA #5 on 1/5/23 at 12:57 PM they stated there was no specific monitoring of the resident when they wanted to leave or pack their belongings. There were no specific monitoring directions on the care instructions. They were unsure if the resident had a wander alert device before the incident on 12/28/22 but the resident did try to remove it. During an interview with LPN Unit Manager #7 on 1/5/23 at 1:15 PM they stated before the incident the resident's CCP was for distant supervision when ambulating, which meant keeping an eye on them from afar. The resident had exit seeked mostly on the second shift. There was no specific monitoring prior to the incident other than checking the wander alert device every shift. The LPN Unit Manager was unsure of any new interventions after the incident. The resident was moved to another unit after the incident. During a telephone interview with CNA #3 on 1/18/23 at 10:04 AM they stated the care plan documented the care the resident needed and was in the computer system. They stated they cared for the resident on the day of the elopement. The care plan only said to keep an eye on the resident with no specific times. There were no other interventions. During a telephone interview with LPN Unit Manager #7 on 1/18/23 at 11:44 AM they stated RNs initiated care plans and they thought the LPN could update them. The resident was at risk for elopement and had a wander alert device as an intervention. Nursing staff would check for placement of the wander alert device. There were no other interventions in place before the elopement. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview with nurse practitioner (NP) #40 on 1/19/23 at 8:48 PM they stated they recalled the resident expressing a desire to leave the facility. If a resident expressed a desire to leave the facility, they expected to be notified and monitoring should be put in place until a team meeting could be held. The CCP should be updated to reflect the potential for elopement and interventions should be put into place immediately. The NP stated the CCP should be updated to reflect medical orders. During an interview with attending physician #41 on 1/19/23 at 9:18 AM they stated the resident was at high risk for elopement as they had expressed a desire to leave. They stated if a resident expressed a desire to leave, they would expect staff to heighten their awareness and include possible interventions such as 1:1 supervision or 15-minute checks. Any intervention should be included in the resident's CCP. During a telephone interview with the DON on 1/19/23 at 9:54 AM they stated the CCP initiated on 4/29/22 was the active care plan prior to the elopement. Changes were made to CCP after the elopement. The DON stated they made the changes to the CCP on 1/8/23. The CCP should be reviewed and revised if there were any changes or if new or worsening behaviors occurred. If a physician ordered behavior monitoring that should be documented in the CCP by the person who obtained the order. Review of the CCP would include making sure it was appropriate and if not, the care plan should be revised. There was no way to determine if the care plan was reviewed unless it was documented in the progress notes. The DON stated they would expect documentation in the nursing notes when the resident expressed a desire to leave and some response to the behaviors in the nursing notes. If the CCP required updating or changes it should be documented. If CCP changes were made on a resident the changes should be verbalized, written, or put in the computerized system. The CNAs would have that information added to their tasks by a licensed nurse. CCPs were to be updated by the Unit Manager or supervisory staff. A RN must initiate a CCP, and LPNs could add info. The nursing supervisor was responsible to update the CCP after incidents or the Unit Manager during the off shifts. The DON did not know why Resident #92's care plan was not updated to reflect interventions for potential elopement of after the elopement. 10NYCRR 415.11(c)(1)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 33420 Based on observation, interview, and record review during the abbreviated survey (NY00308045) the facility failed to ensure the resident environment remained as free of accident hazards as possible and each resident received adequate supervision and assistance devices to prevent accidents for 1 of 5 residents reviewed (Resident #92). Specifically, on December 28, 2022, a cognitively impaired resident (Resident #92) with exit-seeking behaviors was able to leave the facility undetected. Staff were not immediately aware the resident was missing. The resident was last seen wearing a coat and hat at approximately 4:00 PM and was identified as missing at approximately 6:00 PM. Law enforcement was notified at approximately 6:45 PM. Later that evening at approximately 8:00 PM a passing motorist called 911 to report an elderly person walking in the middle of a 4 lane road with their walker and cars swerving around them. The resident was located approximately 4 miles from the facility. The resident was returned to the facility by law enforcement at approximately 8:25 PM. The facility did not educate staff or provide additional supervision to the resident when they returned. The facility did not notify New York State Department of Health (NYSDOH) of the incident until January 4, 2023, after the Department questioned the facility about a report of a possible elopement. The facility investigation was not completed timely and did not identify how and when the resident exited the facility. This resulted in no actual harm with the likelihood for more than minimal harm that was Immediate Jeopardy and Substandard Quality of Care for Resident #92. The facility's failure to provide adequate supervision placed 38 residents with elopement detection devices at immediate risk to their health and safety. Findings include: The facility policy Elopement Prevention revised 2/2020 documented the facility maintained a process to assess all residents at risk for elopement and implemented prevention strategies for those identified as elopement risk. Elopement was defined as a cognitively impaired resident's ability to move about inside the facility aimlessly and without an appreciation of personal safety needs and who may enter into a dangerous situation. There was no documented evidence for a policy or procedure for Code Yellow/Missing resident. Resident #92 had diagnoses including epileptic syndrome (seizures), Parkinson's disease (a progressive neurological disease), neurocognitive disorder with Lewy bodies (a type of dementia), and visual and auditory hallucinations. The 12/13/22 Minimum Data Set (MDS) assessment documented the resident had moderate cognitive impairment, had moderately severe depression, wandered 1-3 of 7 days, required limited assistance of one for walking in their room and the corridor, extensive assistance of one for locomotion on and off the unit, was not steady during walking but was able to stabilize without human assistance, used a walker and a wheelchair, and used a wander elopement alarm daily. The impact of wandering section of the MDS was not completed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The resident's comprehensive care plan (CCP) initiated on 4/29/22 documented the resident was at risk for elopement and exhibited wandering behaviors. The resident had past suicidal ideation, hallucinations, and delusions and the resident was not to leave the facility unattended. Interventions included to distract the resident offering diversions, provide a wander alert device, and check the wander alert device placement every shift. There were no subsequent revisions to the care plan. The Elopement risk assessment dated [DATE] completed by registered nurse (RN) #26 documented Resident #92 was fully ambulatory, wandered aimlessly, had made one plus attempts to elope, and had a wander alert device in place. Nursing notes documented: - on 8/11/22 at 1:50 PM by licensed practical nurse (LPN) #27 Resident #92 was exit seeking and asking staff if their spouse was present. The resident was packing their personal items and the Nurse Manager was notified. - on 8/11/22 at 1:50 PM by LPN #27 Resident #92 was to be monitored for wandering, packing belongings, exit seeking, and verbalizing a desire to leave the facility. The Elopement risk assessment dated [DATE] completed by LPN #28 documented Resident #92 propelled self with some assistance, no attempts or history of elopement, was homeless prior to admission, wandered aimlessly, looked for spouse/loved ones, and had major psychiatric or cognitive impairment diagnosis. Nursing progress notes from 8/11/22-10/21/22 did not include documentation Resident #92 voiced a desire to leave, wandered aimlessly, or made attempts to elope. Nursing progress notes documented: - on 10/21/22 at 2:46 PM by RN #29, psychological services staff #37 interviewed Resident #92 and the resident expressed they did not want to live like this, felt they were a burden to the family, and stated they would walk into the street to kill themself. The resident stated they would not be safe if left in their room alone. Staff were to remain with the resident until transport services were made to send the resident to the hospital. - on 10/21/22 At 2:50 PM by LPN #7, Resident #92 expressed wanting to end their life. 1:1 supervision was initiated until the resident was sent to the hospital as the resident had a plan to kill themself. - on 10/22/22 At 12:01 AM by RN #30, the resident returned to the facility from the hospital without new orders and had three follow up appointments. The resident was placed on 1:1 and staff would take turns during that shift. The wander alert device was in place and functioning. - from 10/22/22-10/28/22 the resident remained on 1:1 for suicidal watch. - from 10/28/22-11/5/22 did not document if the resident wandered, made attempts to elope, expressed a desire to leave the facility, or if the resident was monitored for suicide. There was no documented evidence 1:1 monitoring was discontinued after 10/28/22. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #92 was admitted to a local hospital from 11/5/22-11/10/22 after an unobserved fall and returned to the facility. The nursing admission progress note dated 11/10/22 at 1:02 PM by LPN #28 documented the resident was at low risk for elopement. There was no documented evidence of an elopement risk assessment for 11/10/22. Nursing progress notes documented: - from 11/10/22-11/16/22 there was no documentation the resident had wandering behavior, eloped or expressed a desire to leave. - on 11/17/22 at 8:47 PM by LPN #31, Resident #92 wandered to Unit A South looking for soda. The wander guard was checked for placement. (The A Unit was located on the other side of the building, across a long hall and down one floor from the resident's unit). There was no documented evidence the resident was assessed after the wandering occurred or if the resident was monitored or if the facility investigated to see how the resident got to Unit A South. Nursing progress notes documented: - on 11/18/22 at 5:09 by LPN #7, Resident #92 was not exit seeking, was ambulating around the unit, occasionally confused but easily redirected. - from 11/19/22-12/1/22 there was no documented evidence the resident expressed a desire to leave the facility or eloped. - on 12/1/22 at 6:20 PM by LPN #7, Resident #92 was angry with placement and having to stay at the facility for so long. The resident was reminded they had upcoming appointments related to their health and that they needed more supervision with their current health issues. The wander alert device was in place. - on 12/2/22 at 1:32 AM by LPN #33, the resident had behaviors, was fully dressed in a coat on at 11:30 PM sitting in the chair next to their bed with a wander alert device on their wrist. The LPN redirected the resident, assisted with changing into their pajamas and into bed. The resident was asleep at that time, and they would continue to monitor. - on 12/2/22 at 2:58 PM by LPN #27, Resident #92 was observed by multiple staff ambulating on the unit without an assistive device. Staff encouraged and redirected the resident to use the device and the resident refused. - from 12/2/22-12/7/22 there was no documented evidence the resident expressed a desire to leave the facility or eloped. - on 12/7/22 at 1:29 PM by LPN #27, Resident #92 was upset with moving to room [ROOM NUMBER]-D (3 South) for safety reasons. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- on 12/8/22 at 5:46 PM by LPN #34, Resident #92 walked over to 3 North asking staff how to get out of the building. The nurse checked their wander alert device and directed the resident back to 3 South. Redirection was successful. - on 12/8/22 at 6:32 PM by LPN #31, Resident #92 was exit seeking most of the evening, wanting to get down the elevator to catch a bus. Their wander alert device was in place and medications were given as ordered. The resident was redirected many times. - on 12/9/22 PM by LPN #31, Resident #92 was wandering around the unit without their walker, had difficulty standing and a (certified nursing assistant) CNA put them in a wheelchair (w/c). The resident got themselves up and went to bed. Shortly after, the resident was found wandering in the hall without their walker. The resident had to be redirected many times that evening. The resident was safely in bed and the nurse was at the table right outside the room and would let the oncoming shift know of the behaviors. - on 12/10/22 PM at 5:11 AM by LPN #35, Resident #92 slept very little, was seeking to escape, and was wandering with some confusion. - on 12/15/22 at 12:50 PM by LPN #27, Resident #92 verbalized to staff which door do I use to get out of here. The resident was redirected by staff several times with distraction techniques, i.e., coffee, etc. with negative results. The resident continued to ambulate around the floor with and without their walker. - from 12/16/22-12/26/22 there was no documentation the resident wandered or expressed a desire to leave the facility. - on 12/27/22 at 5:38 PM by LPN #7, the resident required redirection multiple times during the shift. The wander alert device was in place. - on 12/28/22 there was no documented evidence Resident #92 eloped from the facility. The undated facility Full QA (Quality Assurance) Report (Accident/Incident Report) documented an elopement was reported on 12/28/22 at 6:00 PM by Assistant Director of Nursing (ADON) #2. Resident #92 left the facility and was off the premises. The assigned care giver was CNA #3, there were no witnesses, the resident was oriented X 3 (person, place, and time), and had a wander alert device in place. The resident was last observed at 6:00 PM by CNA # 3. The resident was located at their home residence by the resident's family member. There was no wander alert device in place. The elopement details included: - the resident's wander alert device was last checked for functioning and placement at 4:00 PM. - the resident was last seen at 5:00 PM taking a shower. - the resident was noticed missing at 6:00 PM. - the resident was located at 7:30 PM and returned to the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	No injuries were noted. Actions included the call bell was in reach with instruction, family was called to assist with behaviors, the immediate supervisor was notified, the CCP was updated, outside services were required, a skin assessment was completed, and the resident was assessed head to toe with no injuries, 1:1 supervision was in place and a wander alert device was placed on the resident. The conclusion documented Resident #92 ambulated independently with a walker. On 12/18/2022 (wrong date documented) at approximately 6:00 PM, the resident exited the facility without obtaining a pass or stopping at the front desk. Staff notified the supervisor when the resident was not present for dinner. The facility was searched, and the resident was not present. Police were notified and family was contacted. The resident was located at their former home and was returned to the facility. Upon return the resident was assessed for injury and none noted. Upon interview the resident stated they went home to visit their spouse and child. The resident stated they were unaware of the pass policy and did not know one was needed. The resident was reeducated on the process and a wander alert device was placed. There was no documented evidence the facility ruled out abuse, neglect, or mistreatment, where the resident's previous wander alert device was, how the resident got out of the facility, how long the resident was missing, if the policy was followed, or if this incident was reported to NYSDOH as required. During an interview on 1/5/2023 at 12:40 PM CNA #4 stated Resident #92 was alert and oriented some days and some days they were confused. The resident had a wander alert device on their ankle, and they were not sure which ankle. The resident was independent with ambulation, used a walker, and walked around the entire unit. There was no specific monitoring in place when the resident ambulated and since arriving on the unit 1 1/2 weeks ago. The resident had not made attempts to leave the unit. The resident's wander alert device would prevent the resident from getting on the elevator, if it was removed the resident would be able to leave. During an interview on 1/5/2023 at 12:57 PM CNA #5 stated they worked with Resident #92 while on Unit C-South. When the resident first arrived on the unit, they took care of themself, now their cognition had declined rapidly and there was no specific monitoring in place. The resident would pack their belongings daily stating they were leaving. Redirection worked at times. The resident mostly stayed in their room; staff kept a good eye on them. The CNA would not clarify what a good eye meant. Prior to the elopement the resident did not have a wander alert device, was not supervised with ambulation, and had no specific monitoring. During an interview on 1/5/23 at 1:07 PM CNA #6 stated on the day of the elopement 12/28/22, Resident #92 was ambulating on the unit independently, did not require supervision when ambulating and a wander alert device was located on their left arm. The resident had exit seeking behaviors and redirection usually worked. If redirection did not work, they were to tell the nurse or supervisor. Resident #92 was in the hall and in their room that evening and nothing really caught their attention that indicated the resident wanted to leave. When the resident returned on 12/28/22, 1:1 was provided and continued the next day, but they did not document 1:1 was provided. The CNA stated at about 2:00 PM on 12/29/22 Resident #92 was moved to Unit C-South from Unit 3. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 1/5/23 at 1:15 PM LPN #7 stated Resident #92 was alert with periods of confusion, anxiety, and paranoia. They were followed by neurology for behaviors, seizures and followed by psychological services when needed. The resident was at risk for elopement and had a wander alert device on their left wrist. The wander guard had been placed on different parts of the resident's body as the resident removed it multiple times. The residents CCP was updated a couple weeks prior to the incident including requiring distance supervision with ambulation as the resident ambulated a lot on the unit. Distant supervision was defined as staff were to keep an eye on the resident from afar. The resident exit seeked mainly on the second shift and staff were to redirect the resident and talk to them. There was no specific monitoring prior to the incident and the wander alert device was checked for placement every shift. After the elopement they were not sure of any new interventions. The day after the incident the resident was moved to another unit to make it more difficult for them to leave the facility. They did not know if the resident had tried to elope before. During an interview on 1/5/23 at 4:05 PM CNA #39 stated each resident should have an order to go outside. Day passes were provided by nurses only. The resident's elopement status was documented on the care card, and they were not aware of any other ways to identify residents at risk for elopement. Resident #92 was alert and ambulated with a walker. They did not know if the resident required supervision when walking. They never saw the resident exit seeking or packing their belongings and they were not assigned to the residents care that day. At a little after 4:00 PM on 12/28/22 they observed Resident #92 standing in the doorway of their room, in their coat and hat. The resident did not say anything, and the CNA stated they did not tell anyone. The CNA stated that was the resident's normal behavior, and the resident often wore a coat. They did not see the resident after that time, and they were not sure if the resident had on a wander alert device. During an interview on 1/5/23 at 4:33 PM ADON #2 for the 3:00 PM-11:00 PM shift stated when a resident was missing, staff were to report it and a Code Yellow (missing person) was paged overhead. The staff would then search every room and the hallways. If the resident was located an all-clear was overhead paged. If the resident was not located the DON and the Administrator would be contacted and they would take over. On 12/28/22 CNA #3 notified ADON #2 around 6:00 PM that Resident #92 was missing. CNA #3 stated they could not find the resident. The resident was last seen going down the hallway to take a shower before dinner, and CNA #3 did not know where or when the resident was last observed. ADON #2 stated they announced a Code Yellow 3 times, then passed out pictures of the resident they printed off the computer. All staff were searching for the resident and when the resident was not found they called the Director of Nursing (DON) at 6:13 PM. The A and I (accident/Incident) report was initiated by ADON #2. ADON #2 stated they provided a statement for the DON and obtained statements from the staff on the unit. The resident often wore a coat and hat when on the unit and they walked the unit using the walker. They did not document the elopement in the nursing notes and only documented the assessment they performed when the resident returned. When the resident returned to the facility, they placed them on 1:1 and applied a new wander alert device. The resident told staff they took off the wander alert device before they left the building. Staff searched for the wander alert device and were unable to locate it. ADON #2 stated they checked the TAR (Treatment Administration Record) on 12/28/22 and saw the resident's wander alert device was checked at 4:00 PM and was in place. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 1/6/23 at 9:56 AM with Resident #92 they stated they had dementia and it was progressing. They recalled leaving the facility last month at 4:50 PM, no one tried to stop them, and they packed a toothbrush, toothpaste, and a pair of pants. Resident #92 stated being on pass meant they needed permission to leave the facility and they did not ask anyone if they could leave that night, as it was too much work. They had a clear shot out of the building, there were not a lot of people in the lobby and when the receptionist got up, they walked out the front door. No alarms sounded because they left their wander alert device in the bed side drawer as they did not want it to sound. At times they saw things and did not always know where they were. When they were first admitted they thought about hurting themself however did not have any plan now. The resident stated, at times [they] felt alone, like in a fog. The resident stated they did see psychological services however they only came for a few minutes and left stating they would be back. On the night they left the facility they wanted to see the tree, thought about getting home and they did not have any freedom at the facility. They walked all the way to [the street they were located walking in], the sheriff pulled up, and they knew the officer, and the officer took them home. Resident #92 stated they were found walking on the side of the road. The weather was cool outside but not cold, they had their walker and had a coat on. When leaving the facility, they went in the direction of downtown and near a highway, walked around, and saw the tree. The resident stated they bit their wander alert device off and put it in a pocket. When they returned the deputy gave the wander alert device to staff. The resident stated they did not remember much after that. During an interview on 1/18/23 at 10:04 AM CNA #3 stated Resident #92 was previously on the A Unit, moved to 3 South and they were not sure when or why. On 12/28/22 they were assigned to Resident #92. The resident was confused at times. Care needs included the resident was at risk for elopement, they had a wander alert device, staff were to keep an eye on them, and the resident was very fast. The wander alert device was present on their ankle on 12/28/22 at 3:30 PM after the resident finished showering. In the past Resident #92 expressed a desire to leave and would periodically state they wanted to go home. Staff would redirect them and at times that worked. If that did not work, they would notify the Supervisor. The resident did not express wanting to leave the day they eloped. Around 5:30 PM on 12/28/22 they went to check on the resident and could not find then. They looked all over the unit until 5:45 PM, then overhead paged a Code Yellow (missing resident) including the resident's name and room number. The supervisor came to the unit and took over. When the resident returned, they were placed on 1:1 supervision. During an interview on 1/18/23 at 10:34 AM CNA #8 stated they worked as the receptionist at the main entrance a couple of days per week. Training and education included residents going on pass and elopement and there was not much training after that. They were not aware of a picture book for wandering residents at the front desk and did not know how to identify residents who were at risk for elopement unless they had a wander alert device. The front desk was always busy with a lot of people coming and going. They would have to push a button at the desk to let people in and out. They were not familiar with Resident #92, did not know the resident was at risk for elopement, and did not see the resident exit the building. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 1/18/23 at 10:53 AM Business Office Manager #38 stated during an interview on the day of the elopement, they saw Resident #92, at the elevators, on the first floor, approximately 30 feet from the side door entrance. They were not sure what time that was. The resident asked why people were not able to come and go at the side door. Business Office Manager #38 explained to the resident it was for emergency purposes and if people wanted to leave, they would have to come and go at the front entrance. They were not familiar with Resident #92 and did not know the resident was at risk for elopement. They looked at the resident's wrist and did not see a wander alert device and no alarms were going off. The resident then asked about getting money and they stated that would be done at the front desk. The resident thanked them and headed towards the lobby. During a telephone interview on 1/19/23 at 8:48 AM nurse practitioner (NP) #40 stated Resident #92 had expressed the desire to leave the facility. There had been team meetings held however they were not sure about documentation for those meetings. If any resident expressed a desire to leave, they would expect to be notified, monitoring would be put in place soon as possible after the behaviors or verbalizations, and until a team meeting could be held. The care plan should be updated to reflect the immediate interventions in place. During a telephone interview on 1/19/23 at 9:18 AM attending physician #41 stated during a phone interview Resident #92 had a diagnosis of Lewy body dementia. They were very sick, unreliable and their brain was not good. The resident was at high risk for elopement, and they were aware the resident expressed a desire to leave the facility. If any resident expressed a desire to leave the facility, they would expect the staff to heighten their awareness which may include 1:1 or 15-minute checks and should be updated in the resident's care plan. They were aware the resident eloped from the facility on 12/28/22 and stated the resident had no judgement and their cognition was not good. The resident should have been watched more closely if they expressed they wanted to leave. During a telephone interview on 1/19/23 at 10:44 AM the DON stated Resident #92 did not have a diagnosis of dementia in their medical chart. Staff had reported to them the resident expressed on occasion they wanted to go home and be with their spouse. Staff had not reported to them the resident had exit seeking behaviors or expressed a desire to leave the facility. They stated to their knowledge the resident did not attempt to elope before 12/28/22. They were not aware the resident left Unit 3 South and went to the A building to get soda. They stated they would have expected an understanding as to how the resident got off the unit and some form of documentation. They did not know why the elopement was not documented in the nursing notes. ADON #2 completed the elopement incident /accident report, and the DON completed the conclusion on 1/4/23. The DON stated they concluded Resident #92 exited the facility with the intention to go to their home. The resident was not wearing a wander alert device, so the alarms did not sound, and staff let the resident exit the building. After being located by police at their home address, the resident was brought back to the facility. The resident was assessed and had no injuries. The DON stated they determined after looking at the incident reporting manual, due to the resident being alert and oriented without impaired cognition, this was not an elopement and not a DOH reportable incident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 1/18/23 at 12:28 PM the Administrator stated a reportable incidents were incidents that met the standards of reportable guidelines. Reportable incidents included choking, falls with injury, CP violations and abuse. In certain circumstances elopements were reportable and they would have to refer to the reporting manual for guidance. Elopement was defined as someone without capacity that could not make safe decisions and had no regards for their safety wandering out of the facility. Resident #92 had a BIMS (Brief Interview for Mental Status) of 12 (moderately impaired cognition), the resident was able to make decisions and that was considered mild impairment. The Administrator stated they would discuss incidents during QA (Quality Assurance) meetings and at times during morning meetings. In this case, the DON had direct oversight of the investigation. The Administrator stated at first, they did not consider the Resident #92's incident an elopement but after reviewing the police report it could be considered an elopement. An incident report should be completed within 5 days, and if considered abuse, reported within 2 hours. All other incidents were to be reported within 24 hours. Resident #92's investigation should have been completed within 5 days. They had a facility policy elopement prior to 1/5/2023 when DOH entered the building and they were not sure if the policy had been updated. If a resident packed belonging, verbalized wanting to leave or had exit seeking behaviors the wander alert device would be considered the monitoring system. ---------- Immediate Jeopardy was identified, and the facility Administrator was notified on 1/5/23 at 7:57 PM. Immediate Jeopardy was removed on 1/10/23 at 12:28 PM, prior to survey exit based on the following actions taken: -100% on-duty staff education regarding elopement prevention & supervision and additional education for nursing staff, additional staff computerized training prior to starts of shift; -Completion of elopement and wandering assessments throughout the facility. -Revisions to care plans. -Implementation of wander alert device checks and hourly rounding for residents at risk for wandering and other appropriate measures as needed (increased supervision, 1:1). -Resident room changes were made to help mitigate elevator risk and distance from points of exit. -Elopement risk photo collage was updated and included on units. -New (more rugged) bracelet bands for wander alert transmitters; and -Revisions to elopement policy. 10 NYCRR 415.12(h)(1)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 33420 Based on observation, record review and interview during the abbreviated survey (NY00308045), the facility was not administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically. -the facility failed to ensure Resident #92 received adequate supervision to prevent accidents resulting in an elopement. - the facility failed to ensure Resident #92's comprehensive care plan (CCP) was reviewed or revised after the resident stated they wanted to leave the facility, was found exit seeking, and wandered aimlessly throughout the facility. - the facility failed to investigate Resident #92's elopement incident on 12/28/22 thoroughly or timely and did not report the incident to New York State Department of Health (NYSDOH) as required. The facility policy Accident /Incident dated 8/2019 documented the facility was to monitor and evaluate all occurrences of accident/incidents or adverse events occurring on the facility premises. The occurrences must be evaluated and investigated. Any unwitnessed incident or accident must be investigated for potential abuse. -The Director of Nursing (DON) or designee shall ensure the Administrator received a copy of the Incident/Accident packet -The Administrator and DON were responsible to review incident/accident investigations to determine if the incident required reporting to an outside agency i.e., Department of Health (DOH). The NYSDOH Nursing Home Incident Reporting Manual dated 8/2016 documented at least one of the following elements must be present for an elopement incident to be reportable to the NYSDOH: - Resident with cognitive impairment or elopement risk leaves the facility undetected. - Resident, despite cognition, is at risk for elopement and remains missing after search of the building is conducted. - Resident with a pass fails to return from an outing. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #92 had diagnoses including Epileptic syndrome (seizures) Parkinson's disease, neurocognitive disorder with Lewy bodies, attention and concentration deficits and visual and auditory hallucinations. The 12/13/22 Minimum Data Set (MDS) assessment documented the resident had moderate cognitive impairment, had moderately severe depression, wandered 1-3 of 7 days, required limited assistance of one for walking in their room and the corridor, extensive assistance of one for locomotion on and off the unit, was not steady during walking but was able to stabilize without human assistance, used a walker and a wheelchair, and used a wander elopement alarm daily. The impact of wandering section of the MDS was not completed. Refer to citation text F689 for additional details. The comprehensive care plan (CCP) effective on 4/29/22 documented the resident was at risk for elopement due to exit seeking and wandering behaviors. Refer to citation text F656 for additional details. The facility Full QA Report (Accident/Incident Report) documented an elopement was reported on 12/28/22 at 6:00 PM by RN #2. Resident #92 left the facility and was off the premises. The assigned care giver was (certified nurse aide) CNA #3, there were no witnesses, the resident was oriented X 3 (person, place, and time), and had a wander alert device. The resident was last observed at 6:00 PM by CNA # 3. The resident was located at their home residence by the resident's family member. There was no documentation the facility ruled out abuse, neglect, or mistreatment, where the resident's previous wander alert device was, how the resident got out of the facility, how long the resident was missing, if the policy was followed, or if this incident was reported to NYSDOH as required. Refer to citation text for F609 and F689 for additional details. On 1/19/23 at 10:44 AM the Director of Nursing (DON) stated during a phone interview reportable incidents included abuse, injuries of unknown origin, and elopements. They referred to the reporting manual for guidance. Suspected abuse, neglect, mistreatment, and elopements had to be reported to the DOH within 2 hours. Resident #92 was alert and oriented, had a BIMS (Brief Interview for Mental Status) of 12 (moderate cognitive impairment) and did not have a dementia diagnosis. Staff reported the resident expressed wanting to go home and being with their spouse on occurrences, however nothing was directly reported to them about the resident having exit seeking behaviors or expressing a desire to leave. The DON stated to their knowledge the resident did not attempt to elope before 12/28/2022. They were not aware the resident had previously left their unit and went to the A building to get soda and would have expected an understanding as to how resident got off the unit and some form of documentation but not necessarily an investigation. On 12/28/2022 Resident #92 did exit the facility. An investigation was completed, and they concluded Resident #92 exited the facility with the intention to go home. The resident was not wearing a wander alert device therefore the alarms would not sound, and staff let the resident exit the building. The resident was located at their home address and was brought back to the facility by police. They determined after reviewing the incident reporting manual, due to the resident being alert and oriented without impaired cognition, this was not an elopement, so they did not report the incident to NYSDOH. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/19/23 at 1:21 PM The Administrator stated during a phone interview, a reportable incident was an incident that met the standards according to the reportable guidelines including choking, falls with injury, and a CCP violation of abuse. In certain circumstances elopements were reportable and to determine when, they would have to refer to the reporting manual for guidance. Elopement was defined as someone without capacity that could not make safe decisions regarding their safety, who wandered out of the facility. Resident #92 had a BIMS score of 12, was able to make decisions, and was considered mildly cognitively impaired. The Administrator stated they did not have direct oversight of investigations; they discussed accidents/incidents in QA (Quality Assurance) meetings, and at times during morning meetings. In the case of Resident #92, the DON had direct oversight of the investigation. At first, they did not consider the resident's incident an elopement but after reviewing the police report it could be considered an elopement. The accident/incident should have been completed within 5 days and if a reportable incident for abuse it should have been reported to NYSDOH within 2 hours. All other incidents had to be reported within 24 hours. Resident #92's incident investigation should have been completed within 5 days. They had a facility policy prior to DOH entering the building and they did not know if the policy had been updated. If the resident packed belongings, was exit seeking, and/or verbalizing wanting to leave the facility the monitoring system was the wander alert device. 10NYCRR 415.26(a)