STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335753	A. Building B. Wing	08/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bronxcare Special Care Center	1265 Fulton Avenue Bronx, NY 10456

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39170 Based on observation, interviews and record review conducted during an abbreviated survey (NY00298754), the facility did not ensure that a resident receive adequate supervision to prevent elopement. This was evident in 1 out of 3 residents sampled (Resident #1). Specifically, Resident #1 was assessed as a high risk for elopement and had a previous elopement attempt on 06/13/2022. On 07/09/2022 at 9:56 AM, Resident #1 successfully eloped from the facility through the front exit door when Security Guard (SG) #1 buzzed two staff members into the facility. Resident #1 has not been located. The findings are: Review of the facility's policy and procedure entitled Missing Residents updated 09/2021 documented: It is the policy of the facility to ensure that residents do not leave the facility without appropriate authorization and accompaniment. It is the responsibility of all facility personnel to act promptly when residents are seen attempting to leave the building without authorization or found outside an authorized area. Security and all facility personnel shall attempt to prevent departure, obtain assistance from others in the vicinity, announce code M, resident initials, and room number. Review of the facility's policy and procedure entitled Resident Check updated 09/2021 documented: Every resident within the facility will be visualized at least every 2 hours, in a 24-hour day. The CNA completes residents' hourly rounds on a every 2 hourly basis and writes his/her initials accordingly. The CNA visualizes each resident and indicates whereabouts/status according to the code indicated on the resident check sheet. Resident #1 was admitted to the facility with diagnoses including Rhabdomyolysis (breakdown of muscle tissue), Seizure Disorder, Schizoaffective Disorder and Dementia due to Alcoholism. The Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 11/15, indicating moderately impaired cognition. The MDS documented that the resident required supervision for self- performance for bed mobility, transfer, walking, toilet use and personal hygiene. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Hospital Course Notes from 04/08/2022-04/11/2022 documented that Resident #1 wanted to leave Against Medical Advice (AMA), Psychiatry was consulted and stated that the resident did not have capacity. A review of the Hospital and Community Patient Review Instrument dated 04/21/2022 documented that Resident #1 was under 1:1 observation due to wandering and high risk for elopement. A review of the Elopement Risk Assessment tool dated 04/22/2022 documented that Resident #1 was high risk for elopement. A review of the Comprehensive Care Plan (CCP) titled Risk for Elopement was initiated on 04/22/2022. The interventions included: apply wander guard to left ankle, close monitoring, alert security of resident risk for elopement, provide picture and check wander guard daily with monitor for accuracy. There was no documented frequency for monitoring Resident #1 on the Care Plan. A review of a Psychiatry Consult dated 05/13/2022 at 10:21 AM documented that Resident #1 had limitations on orientation but was able to name the place where they were working before. Resident #1 was able to recall how to go from their workplace to their house. Resident #1 did not have capacity to participate in discharge plan due to cognitive limitations. Continue Aricept 5mg once a night. A review of a Nursing Progress Note, by Nurse Manager #3, dated 06/13/2022 at 3:56 PM documented that Resident #1 was alert and oriented x 3. At around 11:20 AM, the resident left the unit to go on the first floor. Resident #1 ran through the front door when the SG #2 opened the front door to let an employee out the building. SG #2 went after the resident and an employee who was standing outside brought the resident back inside the facility. Resident #1 was not wearing their wander guard and stated that they cut it off. A new wander guard was placed on the resident's left wrist. A review of an Elopement Risk Assessment tool dated 06/13/2022 documented that Resident #1 had risk factors for elopement. A review of the Elopement Care Plan revised on 06/13/2022 documented that Resident #1 ran out the building when the SG opened the front door to let an employee out of the building. The interventions included: apply wander guard to left wrist, observe the resident for any behavior that might indicate impeding elopement, monitor resident for wander guard placement every shift, actively involve resident or encourage resident to participate in activities. There was no documented intervention for Resident #1 to leave the unit independently. A review of the Room Check Every 30 minutes sheet from 07/01/2022 to 07/09/2022 documented that Resident #1 was being monitored every 30 minutes as indicated by staff signatures. Documentation showed that Resident #1 was last seen at 9:30AM in the hallway. A review of Nursing Progress Note by LPN #1 dated 07/09/2022 at 4:59 PM documented that Resident #1 was received on the unit at the beginning of the shift alert and responsive. At approximately 10:15 AM, staff reported that Resident #1 ran out the building. The staff reported that he/she and the SG ran after the resident. The resident ran towards 169th Street towards 3rd Avenue then got on a bus. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Nursing Progress Note, by Nurse Manager (NM) #1, dated 07/09/2022 at 8:12 PM documented that the CNA #1 reported that Resident #1 exited the building by prying open the second sliding door. CNA #1 alerted the SG #1. According to the CNA #1, he/she and the SG #1 pursued the resident who went towards 3rd Avenue. The staff were told by a pedestrian that the resident boarded a city bus that was going towards [NAME] Road. A search party was activated, and they searched the neighborhood for two and a half hours. 911 and the Police were informed, and the DON was notified. A review of the facility Investigation dated 07/12/2022 documented that on 07/09/2022 at around 9:56 AM, Resident #1 exited the building through the front door. A staff member was entering the facility, saw Resident #1 and tried to redirect Resident #1 without success. The staff member immediately notified Security and they both pursued Resident #1 who began to run left down 169th Street and right into 3rd Avenue. Resident #1 went on to a bus heading towards [NAME] Road. Security thought Resident #1 was a staff member. SG #1 opened, the door to let a visitor and staff into the facility. The staff asked the resident where they were going but the resident kept walking. Resident #1 was assessed as an elopement risk and had a history of removing their wander guard. The facility concluded that the staff responded promptly and alerted the Security. Resident #1 was kept under close monitoring. The facility concluded that staff responded promptly. The facility surveillance video was viewed with the DON on 07/12/2022. Recording of 07/09/2022 revealed the following: 9:56AM - SG #1 was observed sitting at the Security's desk. 9:56 AM- Resident #1 appeared in the camera walking in the lobby through the security swing gate (turnstile) opposite the Security desk. Resident #1 went directly to the front exit door. Resident #1 had a red bandana on their head and was wearing a dark colored short sleeve T-shirt and pants. 9:56 AM- Resident #1 pressed the button to the right of the inner exit door and was seen pulling on the left side of the inner sliding door as SG #1 buzzed in a staff member through the entrance. 9:56AM- Security Guard still sitting at Security's desk. 9:56AM - Resident #1 was seen going through the front doors and as DS was entering the facility. 9:56AM - Just behind the DS, CNA #1 was entering through the front door. CNA #1 seen turning in the direction of Resident #1 while Resident #1 was on the top platform outside the front door. 9:56AM -CNA #1 observed talking to SG #1 while Resident #1 continued down the steps and started running. 9:56AM -SG #1 got up from the desk and went outside with CNA #1. 9:56AM -SG #1 and CNA #1 went down the steps and started running after Resident #1. 10:02 AM- SG #1 and CNA #1 returned to the facility without Resident #1. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations were conducted of the facility's Security System and of all residents' units on 07/12/2022. There were two sets of sliding doors in the front lobby to the left of the Security desk. Security Guard must buzz to let staff and visitors in and out. The inner sliding door can also be manually opened if one presses hard on the knob to the right. In the lobby there is a security swing gate (turnstile) opposite the Security desk that everyone must walk through to get to the Security desk and to the front exit doors. The swing gate must be opened by a SG. The facility has 4 alarm systems, 3 alarms are in the lobby and one at the back entrance. One alarm is at the first sliding door and one alarm is at the side entrance. No staff or residents are allowed to use the side doors. Two video cameras observed in the main lobby. At the SG's desk there are 16 monitors, monitoring the units and outside of the front entrance. There was no wander guard alarm system on the two elevators. During an interview on 07/12/2022 at 11:00 AM, CNA #2 stated that he/she was assigned to Resident #1 on 07/09/2022. CNA #2 stated that he/she observed Resident #1 lying in bed awake while he/she made rounds at 8:00 AM. CNA #2 stated that Resident #1 went in the Dining Room for breakfast at around minutes to 9:00 AM but Resident #1 did not eat breakfast. CNA # 2 stated that he/she monitored Resident #1 every 30 minutes. CNA #2 stated that he/she last observed Resident #1 walking in the hallway at around 9:30 AM. CNA #2 stated that Resident #1 did not have on a wander guard on 07/09/2022. During an interview on 07/12/2022 at 10:55 AM, the Dietary Supervisor (DS) stated that on 07/09/2022 around 10:00 AM, when reporting to work, he/she buzzed at the front door to gain access to the facility. The Dietary Supervisor said that someone exited the building that he/she did not recognize. DS stated that CNA #1 came in behind him/her. During an interview on 07/12/2022 at 11:10 AM, CNA #1 stated that on 07/09/2022 around 10:00 AM, he/she saw Resident #1 on the stairs outside the building and asked the resident where they were going. CNA #1 stated that Resident #1 did not answer. CNA #1 stated that he/she was entering the building just behind the Dietary Supervisor and informed SG #1 that Resident #1 was outside. CNA #1 stated that he/she and SG #1 both went outside to catch Resident #1. CNA #1 stated that Resident #1 was seen running and they could ' t catch up to the resident. During an interview on 07/12/2022 at 11:20 AM, SG #1 stated that he/she was the SG on duty when Resident #1 left the faciity on [DATE]. SG #1 stated that he/she worked at the facility on weekends. Stated that he/she was not aware that Resident #1 was a resident and that they were at risk for elopement. SG #1 stated that he/she thought that Resident #1 was a staff member, since Resident #1 was young. SG #1 stated that visitors do not sign out at the Security desk. SG #1 stated that Resident #1 first went through the swing gate in the building (the gate leads to the front desk) which SG #1 had opened for a staff member and left the gate in an open position. SG #1 stated that he/she buzzed the front door open for CNA #1 and another staff member (the DS) and Resident #1 exited the front door around at 10;00 AM. SG #1 stated that CNA #1 alerted him/her that Resident #1 was a resident. SG #1 stated that he/she and CNA #1 immediately went after Resident #1 and saw Resident #1 running up the street in front the building ([NAME] Street). Stated that Resident #1 turned unto 3rd Avenue and when SG #1 and CNA #1 got to 3rd Avenue, a bystander informed them that Resident #1 had boarded a bus. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/12/2022 at 11:00 AM, Registered Charge Nurse (RCN) #1 stated that all the residents are monitored every two hours. RCN #1 stated if a resident is at high risk for elopement, then the resident is placed on every 30 minutes monitoring. RCN #1 stated that he/she heard Resident #1 stating that they wanted to leave and will go downstairs. RCN #1 stated that Resident #1 did not have a home in the community and did not have capacity to make decision for discharge. RCN #1 stated that SG #2 previously called staff member to get Resident #1 from the lobby. RCN #1 stated that Resident #1 did not show any indication that he/she wanted to leave the facility prior to June 13, 2022. RCN #1 stated that a wander guard was reapplied on Resident #1. RCN #1 said Resident #1 had a history of removing the wander guard. RCN #1 stated when Resident #1 removed the wander guard, RCN #1 placed it in a different area. RCN #1 stated when he/she left work on 07/08/2022, Friday evening Resident #1 was wearing a wander guard on their right ankle. RCN #1 stated he/she checked the monitoring sheet to ensuring that staff members are signing the sheet. During a follow up interview on 08/08/2022 at 9:56 AM, RCN#1 stated that he/she observed Resident #1 left the unit independently several times after their first elopement attempt (06/13/2022). RCN #1 stated that Resident #1 had the right to go on the elevator and leave the unit independently. RCN #1 stated that the facility could not restrain Resident #1. RCN #1 also stated that there was no care plan in place for Resident #1 to go off the unit independently. During an interview on 07/22/2022 at 9:55 AM, the Registered Nurse Manager (RNM) #1 stated that he/she worked at the facility part time on weekends. RNM #1 stated that he/she made rounds during the morning on 07/09/20222 on Resident #1 ' s unit prior to the elopement (could not recall the time) but did not see Resident #1. RNM #1 stated that he/she went to the nurse's station. RNM #1 stated that Resident #1 was on frequent checks every 30 minutes and Resident #1 should have been wearing a wander guard. RNM #1 stated that on 07/09/2022 at around 10:00 AM, CNA #1 alerted him/her that Resident #1 had left the building. RNM #1 stated that he/she immediately initiated a search party and informed the Director of Nursing. RNM #1 stated that he/she was informed that Resident #1 entered a city bus and was not found. During a follow up interview on 08/08/2022 at 10:30 AM, RNM #1 stated that Resident #1 was allowed to leave the unit independently after their first elopement attempt (06/13/2022). RNM #1 stated that he/she was not sure if there was a care plan in place for Resident #1 to leave the unit independently. RNM #1 also stated that there should have been a care plan for Resident #1 to go off the unit independently. During an interview on 07/22/2022 at 11:14 AM, Licensed Practical Nurse #1 (LPN #1) stated that he/she was regularly assigned to the unit and was familiar with Resident #1 ' s care. LPN #1 stated that on 07/09/2022, he/she arrived at work between 8:00 AM-8:15 AM and made rounds. LPN #1 stated that he/she saw Resident #1 in their room in the bathroom. LPN #1 stated that around 8:30 AM- 9:00 AM (not sure of exact time), he/she saw Resident #1 sitting in the dining room. LPN #1 stated that he/she last saw Resident #1 walking in the hallway between 9:30 AM and minutes to 10:00 AM. LPN #1 stated that around 10:15 AM, he/she was made aware that Resident #1 left the facility. LPN #1 stated that he/she then informed the RNM #1. LPN #1 stated that Resident #1 was on every 30 minutes, and he/she observed Resident #1 with their wander guard on one of their wrists when he/she made rounds but Resident #1 had a habit of removing their wander guard. LPN #1 stated that Resident #1 was allowed to go off the unit independently. LPN #1 stated that he/she was not aware that Resident #1 made a prior attempt to leave the facility on 06/13/2022. LPN #1 also said that Resident #1 never informed him/her that they wanted to go home. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/12/2022 at 6:35 PM, the Director of Nursing (DON) stated that Resident #1 was assessed as high risk for elopement on admission and a wander guard was applied on Resident #1. The DON stated that he/she was aware that Resident #1 was on 1:1 in hospital but the facility could not implement 1:1 due to staffing issues. The DON stated that a wander guard was applied on Resident #1 but Resident #1 kept removing the wander guard. The DON stated that staff checked for placement and functionality of wander guards, but it was not documented. The DON stated that Resident #1 was on every 30 minutes monitoring. The DON said that Resident #1 was quiet and did not verbalize wanting to leave until an attempt on 06/13/2022 when Resident #1 was stopped by SG #2. The DON stated that wander guard was reapplied on Resident #1 and every 30 minutes monitoring continued. The DON stated that the unit nurses oversee that the CNAs perform the monitoring. The DON stated that Resident #1 was allowed to go off the unit to activities on the first floor independently and staff would alert Security when Resident #1 left the unit by elevator to the first floor. The DON stated that on 07/09/2022, staff did not see when Resident #1 left the unit therefore SG #1 was not notified. The DON stated that Resident #1 ' s picture was at the Security desk and the picture was probably given to the police for identification purpose. The DON stated that Resident #1 was still not found. The DON stated that on 07/09/2022, SG #1 did not follow the facility protocol: SG #1 left the turn style (swing gate) open and did not validate the identity of Resident #1. The DON stated that SG #1 was supposed to sign in and sign out visitors. The DON stated that the standard monitoring for residents is every 2 hours. The DON stated that the facility is looking into placing alarms in the elevators, making residents at risk for elopement pictures colored, having staff document on wander guard checks ever shift and re-in-servicing all staff on elopement prevention and Security on visitation sign in and out protocol. The DON stated that approximately 80 % of staff were re-in-serviced. 415.12(h)(2)