STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335023	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A Holly Patterson Extended Care Facility	875 Jerusalem Avenue Uniondale, NY 11553

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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** Based on observations, record review, and staff interviews, the facility failed to provide adequate supervision and a safe environment for each resident. This was identified for one (Resident #3) of five residents reviewed for elopement. Specifically, Resident #3 who had severe cognitive impairment, exit seeking behaviors, and was at high risk for elopement, exited their fourth-floor room through a window and fell to a second-floor patio (awning roof) sustaining multiple fractures (broken bones) on 03/03/2026. Upon the resident's return from the hospital to the facility on [DATE], the resident was placed back onto the fourth floor and continued to have access to the windows in their room. The facility's Elopement Risk Assessment tool failed to evaluate residents for exit-seeking behaviors or the risk of elopement through windows. The Comprehensive Care Plan interventions were not updated to address window safety in Resident #3's room to prevent future elopements through the window. This resulted in the potential for serious injury, serious harm, serious impairment, or death for 82 residents identified as elopement risks, that is Immediate Jeopardy. The findings include: The facility's policy titled Resident Elopement dated 06/2025 documented that the facility will ensure staff has knowledge of resident's whereabouts at all times. The facility will provide measures to ensure the safety and well-being of those residents who are considered at risk to wander from the facility. Resident rounds are conducted by nursing staff for safety every shift. Each resident is assessed initially upon admission, and on an ongoing basis to determine their potential risk for wandering behavior or elopement. Assessment shall be based on factors including but not limited to capacity, judgment, and history of wandering behavior. Care plans shall be revised as indicated, when there is a change in elopement/wandering behavior, or when a particular intervention is no longer effective. Staff should be aware of times of day when behaviors may escalate, and heightened monitoring may be indicated. Resident #3 was admitted with diagnoses including frontoparietal infarct (a type of stroke or tissue death affecting the front and upper side of the brain), aphasia (language and communication disorder caused by brain damage) and altered mental status. The admission Minimum Data Set (a resident assessment tool) dated 12/22/2025 documented a Brief Interview for Mental Status score of three, which indicated Resident #3 had severe cognitive impairment. Resident #3 had behavior of wandering. Resident #3's wandering placed the resident at significant risk of getting to a potentially dangerous place including stairs, or outside of the facility. Resident #3 was independent with mobility and did not use any assistive device.A Comprehensive Care Plan dated 12/24/2025 titled, Secure Placement related to Elopement Risk documented interventions including moving the resident to a locked, secure unit, placement of a wander guard (a wearable bracelet and door sensors to track resident's movement and trigger automated alerts or lock doors if a resident nears an exit) and on-going staff redirection and education.The Risk Assessment Elopement Decision Tree form dated 12/15/2025 documented that Resident #3 was ambulatory (ability to walk and move independently) and was cognitively impaired with poor decision-making skills. The resident displayed behaviors and body language indicating an elopement may be forthcoming. The interventions were to provide a wander detection system (wander guard), staff education, notation on the Certified Nursing Assistant (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Accountability Record (resident care instructions), and security notification by forwarding the resident's information and photo. A Nursing Progress Note dated 12/16/2025 documented that Resident #3 attempted to exit the unit (on the first floor) multiple times and was unable to be redirected by nursing staff. Resident #3 was observed fully dressed carrying their passport and a bag indicating that elopement was forthcoming. Resident #3 was transferred to a secure unit on the fourth floor. A Social Work Progress Note dated 12/16/2025 documented Resident #3 attempted to leave the facility by opening a door. The resident was moved to the fourth floor (secure locked unit) for safety. A review of the medical record from 12/17/2025 through 03/03/2026 did not document exit seeking behaviors or elopement attempts by Resident #3. A Nursing Progress Note dated 03/03/2026, written by Registered Nurse #10, documented that at approximately 4:15 AM, Resident #3 was standing outside a second-floor room window (Unit 21). Resident #3 was assisted back inside the facility through the window and was taken back to their unit on the fourth floor (Unit 41) for a full body assessment. The physician was notified and Resident #3 was sent to the hospital for evaluation. A review of the facility's Accident and Incident report initiated on 03/03/2026 documented that Resident #3 was observed on the second-floor patio (awning roof) outside a window of room [ROOM NUMBER]. The resident was unable to give account of the occurrence. The facility investigation summary documented the resident was last seen at 3:30 AM, lying in their bed. Resident #3 did not exhibit active exit seeking behaviors such as activating door alarms, lingering near exit doors, or packing belongings. Based on the facility findings, Resident #3 had fully dressed themself, packed their personal belongings, broke the window lock, and exited through the window. Resident #3 intentionally attempted to leave the facility. A review of a form titled, Head Count from 03/02/2026 - 03/03/2026 documented that Resident #3 was observed sleeping in their bed during hourly rounds at 11:00 PM, 12:00 AM, 1:00 AM, 2:00 AM and 3:00 AM. A review of the hospital emergency room progress note dated 03/03/2026 at 7:23 AM documented that Resident #3 was admitted to the emergency department for an unwitnessed fall from an unknown height. The resident sustained multiple fractures including retrosternal hematoma (blood pooled behind the chest bone), sternal (chest bone) fracture, spinal compression fracture (collapse of the bone in the spine), and comminuted (bone shatters into multiple pieces) ankle fracture. The nursing admission progress note dated 03/11/2026 documented the resident was readmitted to the facility on [DATE] on the fourth-floor secure unit. There is no documented evidence that the Elopement Risk Assessment was completed for Resident #3 upon their return from the hospital on [DATE]. The Comprehensive Care Plan titled, Secure Placement related to Elopement Risk dated 12/24/2025 was updated on 03/11/2026 to include a new intervention of every 30 minutes visual checks for three days. There was no documented evidence that interventions related to monitoring the window to prevent future elopements through the window were added to Resident #3's Comprehensive Care Plan. During an observation on 06/25/2026 at 9:18 AM, Resident #3 was sitting on their bed which was closer to the door as opposed to the window. Resident #3 was ambulatory and was unable to communicate. Resident #3's room window was observed with an anti-tilt lock with two additional screws, an L-bracket (an L shaped fastener) on each side of the window, and another lock to prevent the window from opening more than six inches. During an interview on 06/24/2026 at 9:18 AM, Certified Nursing Assistant #5 stated they were regularly assigned to Resident #3 during the 3:00 PM - 11:00 PM shift. Certified Nursing Assistant #5 stated at times they also work during the 11:00 PM - 7:00 AM shift and are responsible for conducting hourly rounds. Certified Nursing Assistant #5 stated when they make the hourly rounds, they check to see if the resident is in the room. Certified Nursing Assistant #5 stated when Resident #3 returned from the hospital on [DATE], they did not receive instructions to check Resident #3's room windows for tampering during the hourly rounds. Certified Nursing Assistant #5 stated they do not check the resident's room windows. During an interview on 06/24/2026 at 9:33 AM, Licensed Practical Nurse #2, the 7:00 AM - 3:00 PM unit charge nurse, stated they were aware of the incident related to Resident #3 jumping out of the window and that the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	resident was at risk for elopement. Licensed Practical Nurse #2 stated that if they notice broken window glass or broken window locks, they will report to the maintenance staff; however, they do not routinely check for the window integrity in resident rooms. Licensed Practical Nurse #2 stated that after Resident #3 returned from the hospital, there were no instructions for the nursing staff to check Resident #3's room windows for any tampering. During an interview on 06/24/2026 at 9:45 AM, the 11:00 PM - 7:00 AM shift Certified Nursing Assistant #16 stated they were assigned to conduct the hourly resident head count on 03/03/2026 at 3:00 AM. Certified Nursing Assistant #16 stated they saw Resident #3 at 3:00 AM lying in bed. Certified Nursing Assistant #16 stated they did not check the room window. Certified Nursing Assistant #16 stated that after Resident #3 returned from the hospital, no specific instructions were provided to check the room windows for tampering. They continue to conduct the routine hourly headcounts without checking the resident room windows. During an interview on 06/25/2026 at 9:00AM, Certified Nursing Assistant #15 stated that prior to the incident on 03/03/2026, they went to the resident's room at 3:30 AM and the resident was sleeping in their bed. They did not turn on the lights and walked up to the room's window to look outside. They did not notice anything unusual with the window. Certified Nursing Assistant #15 stated when Resident #3 returned from the hospital, there were no specific instructions related to checking the window integrity in Resident #3's room. Certified Nursing Assistant #15 stated they continued to conduct the hourly head count rounds as before without the window safety checks. During an interview on 06/25/2026 at 9:59 AM, Nurse Educator #1 stated that after Resident #3's elopement incident, they provided education to the public safety staff related to identification of all residents who are at risk for elopement and resident safety. Nurse Educator #1 stated that the lesson plan did not include window safety instructions. There was no documented evidence that in-service education was provided to nursing staff related to window safety or window monitoring after Resident #3 jumped out of the window on 03/03/2026. During an interview on 06/25/2026 at 1:19 PM, Registered Nurse #11, the charge nurse, stated that after they sent Resident #3 to the hospital on [DATE], they were not sure if the care plan for Elopement was updated to include interventions for window safety. Registered Nurse #11 stated that Registered Nurse Supervisor #10 was responsible for updating care plans. During an interview on 06/25/2026 at 1:30 PM, the Director of Nursing Services stated since Resident #3 was moved to the fourth floor, they did not have any exit seeking behaviors or attempts of elopement, prior to 03/03/2026. The Director of Nursing Services stated that Resident #3 was wearing a wander guard and resided on a secure unit. There are hall monitors on the secured unit who are responsible for conducting an hourly head count and monitoring the residents' whereabouts. The Director of Nursing Services stated that when Resident #3 returned from the hospital on [DATE], the Comprehensive Care Plan interventions did not include window safety checks by the nursing staff because window safety was a Maintenance process and not Nursing. The Director of Nursing Services stated they did not know the frequency of the window checks conducted by the maintenance staff. The Director of Nursing Services verified that the facility's elopement risk assessment did not evaluate the potential for elopement through windows. Additionally, the elopement risk assessment did not consider residents' history of eloping through a window to determine further elopement from the window and implement appropriate interventions. During an interview on 06/25/2026 at 2:55 PM, Registered Nurse #10, the unit supervisor for the 11:00 PM - 7:00 AM shift, stated they were the nursing supervisor on duty on 03/03/2026 when Resident #3 jumped from the fourth-floor window and was found outside the second-floor window. They assessed Resident #3, notified the physician, and the resident was sent to the hospital. Registered Nurse #10 stated they were responsible for updating the resident's care plan; however, they could not recall why they did not update Resident #3's Comprehensive Care Plan after the resident's return from the hospital on [DATE]. During an interview on 06/26/2026 at 9:15 AM, the Administrator stated that an Ad hoc (meeting for immediate purpose rather than planned or intended for a wider application) meeting was immediately held on 03/03/2026 to discuss the incident and needed interventions. The Administrator stated when Resident #3 returned (continued on next page)

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