STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335070	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brooklyn Gardens Nursing & Rehabilitation Center	835 Herkimer Street Brooklyn, NY 11233

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** 43285 Based on observation, record review, and interviews during an abbreviated survey (NY00359265), the facility did not ensure each resident received adequate supervision to prevent an elopement. This was evident in 1 out 16 residents (Resident #1) sampled for elopement. Specifically, the facility Surveillance Camera Recording dated 11/02/2024 showed Resident #1 walked past Security Guard #1 at 11:00 AM, who was sitting at the front desk in the lobby and exited the automatic front doors and eloped from the facility. Resident #1 then walked past a second (Security Guard #2) who was sitting in a booth at the front gate that leads to the street. Facility staff became aware between 12:30 PM and 1:00 PM that Resident #1 was missing. According to an interview with the Director of Nursing on 12/22/2024 at 12:30 PM, a hospital staff notified facility staff on 11/04/2024 that Resident #1 was at the hospital. Resident #1 was readmitted to the facility on [DATE] with no injuries. The findings include: The facility's Policy and Procedure titled Elopement Prevention/Wandering Behavior Management dated 08/12/2022 states it is the policy of the facility to utilize all possible measures to maintain the safety and well-being of all residents. To have system and tools in place to do all that is reasonable to identify and prevent unsafe wandering and/or elopement and to act quickly and prudently should it occur. The facility's Policy and Procedure titled Security Reception Desk dated 08/31/2023 states that the facility will ensure that the environment is safe and secure for residents, employees, and visitors twenty-four hours throughout the day. The facility will employee trained security guards to work at the Front Desk reception area at all times to monitor entrance and exit from the building and respond to any alarms activated. Resident #1 was admitted to the facility with diagnoses including Schizophrenia Disorder and Cerebral Infarction. The Minimum Data Set (an assessment tool) dated 05/23/2024 documented Resident #1 had a Brief Interview of Mental Status (used to determine attention, orientation, and ability to recall information) score of 12 associated with moderate cognitive impairment. Resident #1 ambulates with a rollator walker. (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	An Elopement Risk assessment dated [DATE] documented Resident #1 was not identified at risk for elopement. Therefore, an elopement care plan was not implemented. A document titled Department of Nursing Rounds dated 11/02/2024 showed Resident #1 was on hourly monitoring and was last seen on the unit at 11:00 AM. A nursing progress note dated 11/02/2024 at 8:27 PM, by Registered Nurse Supervisor #1, documented Resident #1 could not be found on the unit. Registered Nurse Supervisor #1 stated Resident #1 has never verbalized wanting to leave the facility and that Resident #1 had a discharge plan in progress. Resident #1 used a rollator for ambulation. A unit search was done, and Coded Pink (elopement code) called. The Director of Nursing and Resident #1's family member was notified, and 911 was call for missing person. The search continued. A Surveillance Camera Recording dated 11/02/2024 at 11:00 AM, showed Resident #1 exited the elevator in the lobby with their rollator walker, and walked past Security Guard #1 at the front desk and exited through the automatic front door Security Guard #1 was observed talking to Resident #2 at the time exited the automatic front doors. Resident #1 also walked past Security Guard #2, who was sitting in a booth at the front gate, and exited the front gate that leads to the street. Neither Security Guard #1 nor Security Guard #2 stopped Resident #1. An Investigation Summary dated 11/02/2024 documented Certified Nursing Assistant #1 reported that they last saw Resident #1 at 11:00 AM. Certified Nursing Assistant #1 stated at around 12:00 PM they were feeding residents and at 1:00 PM they observed Resident #1 did not eat their lunch. Certified Nursing Assistant #1 stated they checked Resident #1's room and the first floor and Resident #1 was not found. Licensed Practical Nurse #1 and Registered Nursing Supervisor #1 were notified. All floors were search and Resident #1 not located. Code Pink was initiated. Staff members search inside and outside the building and adjacent streets and Resident #1 was not found. Local law enforcement was called and responded. Resident #1 was found on 11/04/2024 and was returned to the facility on [DATE]. The investigation concluded there is no evidence of abuse, neglect, or mistreatment. Resident #1 was schedule for discharge and was waiting for home care approval when they decided to leave the facility. Multiple attempts were made to reach Security Guard #1 and # 2 were unsuccessful. Security Guard #1's statement dated 10/02/2024 (error its 11/02/2024) documented at approximately 2:30 PM they were informed Resident #1 left the facility using a walker. They did not see anyone leaving the premises but was told by another resident (Resident #2) that Resident #1 left during smoke break. Security Guard #2's statement dated 10/02/2024 (dated should have been 11/02/2024) documented at 12:30 PM the nurse asked them if they see Resident #1 with a walker comes out of the elevator. Security Guard #2 documented no because they were printing the logbook and was not paying attention because so many people come in with a walker. They did not see anybody with a walker and a bracelet badge on their right hand walked out. (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 11/22/2024 at 12:00 PM, Licensed Practical Nurse #1 stated they last saw Resident #1 between 10:50 AM and 11:00 AM on the unit walking with their rollator walker. Licensed Practical Nurse #1 stated they came to the lobby at around 12:30-1:00 PM and Resident #2 informed them that they saw Resident #1 going toward the front gate. Licensed Practical Nurse #1 stated they went in search for Resident #1 but did not find them. During an interview on 11/22/2024 at 11:57 AM, Registered Nurse Supervisor #1, who worked on 11/02/2024 on the 7:00 AM to 3:00 PM shift, stated Resident #1 was on hourly monitoring and was last seen at approximately 11:00 AM on the unit ambulating with their rollator walker. Registered Nurse Supervisor #1 stated Resident #1 was ambulating to and from their room into the hallway. Registered Nurse Supervisor #1 stated Resident #1 never verbalized wanting of leave or exhibited any exit seeking behavior. Registered Nurse Supervisor #1 stated Resident #1 had a discharge planning in progress and that Resident #1 was aware. Registered Nurse Supervisor #1 stated there were two Security Guards (#1 and #2) on duty at the time Resident #1 exited the facility. Registered Nurse Supervisor #1 stated Security Guard #1 was assigned to monitor the front desk and Security Guard #2 the front gate. Registered Nurse Supervisor #1 stated the process is that security must check identification and asked questions to ensure a resident is not leaving the facility. Registered Nurse Supervisor #1 stated Resident #1 was wearing an identification band when they exited the facility. Registered Nurse Supervisor #1 stated approximately 12:30 PM -1:00 PM (not sure of the time) staff observed that Resident #1 was not on the unit. Registered Nurse Supervisor #1 stated the staff searched for Resident #1, but the resident was not found in the building and Code Pink was activated. Registered Nurse Supervisor #1 stated they called the Director of Nursing and informed them, and they were instructed to call 911. Registered Nursing Supervisor #1 stated 911 was called at 1:00 PM and responded at 5:28 PM. Registered Nurse Supervisor #1 stated all residents are assessed for elopement risk upon admission to the facility. Registered Nurse Supervisor #1 stated Resident #1 was not identified to be an elopement risk. During an interview on 11/22/2024 at 2:00 PM, the Administrator stated they were made aware of the elopement at 2:00 PM on 11/02/2024. The Administrator stated they went to Resident #1 last known address at 7:45 PM and the doorbell was not answered. The Administrator stated they searched many areas including shelters and hospital but Resident #1 was not located. The Administrator stated Resident #1 exited the building via the front door while Security Guard #1 was at the front desk and Security Guard #2 was at the front gate. The Administrator stated Security Guard #1 and #2 received classroom education and buddy up with a co-worker prior to them starting work. The Administrator stated Security Guard #1 supposed to check all visitors and resident entering and leaving the facility. The Administrator stated Resident #1 was wearing an arm band with their name and room number. The Administrator stated that visitors entering the facility are given a pass to wear in the facility after signing the Kiosk. Visitors must return the pass whenever they are leaving the facility. The Administrator stated Security Guard #1 and #2 did not follow the facility policy and were terminated. The Administrator stated they are responsible for tracking and monitoring all the security guards working in the facility. (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 11/22/2024 at 2:30 PM, the Director of Nursing stated Resident #1 was assessed for elopement risk upon admission and was not identified at risk for elopement. The Director of Nursing stated that Certified Nursing Assistant #1 signed Resident #1's monitoring sheet at 12:00 PM identifying Resident #1 was Off Unit. The Director of Nursing stated all staff members received in-service that they must visually see the resident before signing the hourly sheet. The Director of Nursing stated the investigation concluded that there is no evidence of abuse, neglect, or mistreatment. Resident #1 was schedule for discharge and was waiting for home care approval when they decided to leave the facility. Based on the following corrective actions taken, there were sufficient evidence that the facility corrected the noncompliance and was in substantial compliance for this specific regulatory requirement 11/18/2024 prior to surveyors' s onsite visit on 11/22/2024. A Plan of Correction is not required for this citation. The facility implemented the following corrective action prior to surveyor entrance on 11/22/2024. The facility's Director of Nursing investigated the elopement incident and the team concluded that Resident #1 leave the facility unescorted. The facility developed an action plan which includes the following: On 11/02/2024 local law enforcement was called 11/02/2024 at 1:00 PM and responded on 11/02/2024 at 5:28 PM. Resident # 1 information and picture was given to the local police. On 11/02/2024 facility re-in-serviced staff members from all departments on elopement, visual monitoring, and checking identification band (in-service ongoing). Quality Assurance Meeting held on 11/04/2024 with department heads. Attendance sheet reviewed. On 11/03/2024 Security Guard #1 and #2 terminated. Policy and Procedure for Reception Desk dated 08/31/2023 was revised on 11/11/2024 to reflect on a new button installed at security desk to allow only Security Guards to open the door front door from the inside. A Transaction Receipt dated 11/11/2024 for the locksmith to install the push button for front door was reviewed. On 11/12/2024 Resident #1 was readmitted to the facility without injury. On 11/13/2024 Resident #1 was observed walking toward the entrance and was stop. A wander guard bracelet was applied. A nursing progress note dated 11/13/2024 documented Resident #1 and family received education and verbal consent was given for wander guard. An elopement care plan was implemented on 11/12/2024 for Resident #1. On 11/15/2024 an Elopement Drill was done with staff members. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Audit tool dated 11/18/2024 was developed to monitor compliance with residents at risk for elopement/wandering. The 2nd entrance door will be kept locked. Only Security Guard in the reception area can open the door. Security Guard will ensure residents are not in the space between 1st and 2nd entrance glass door. Residents can only stay in between the 1st and 2nd entrance door if a recreation staff is present. Policy and Procedure dated 08/12/2022 Elopement prevention/Wandering behavior reviewed with no revision. Policy and Procedure for Reception Desk dated 08/31/2023 reviewed with revision on 11/11/2024 to reflect on a new button that was installed at security desk to allow only Security Guards to open the door from the inside. 10 NYCRR 415.12(h)(2)