STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335154	A. Building B. Wing	11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Nursing Care Center	119 15 27th Avenue Flushing, NY 11354

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. 43285 Based on observation, interviews, and record review conducted during an abbreviated survey (NY00323743), the facility failed to ensure that each resident receives adequate supervision to prevent elopement. This was evident in 1 of 3 residents reviewed for elopement risk (Resident #1). Specifically, on 09/12/2023 at 7:15 AM, Resident #1 left the facility undetected by staff. Resident #1 was located by the police at their family member's house on the same day at 3:15 PM. The findings: The facility policy titled Elopement/Attempted Elopement dated 11/2022 stated an elopement in a skilled nursing facility is when a resident who does not have competency to make their own decisions leaves the facility without the knowledge of the staff. This is a very dangerous and serious for the resident. It is the responsibility of every employee to be aware of the location of such residents and to prevent this situation. The policy stated that the staff shall investigate and report all cases of missing residents. The facility policy titled Resident Checks dated 12/2022 stated it is the policy of the facility that staff shall make routine resident checks to help maintain resident safety and well-being. Routine resident checks involve entering the resident's room and / or identifying the resident elsewhere on the unit to determine if the resident's needs are being met, identify any change in the resident's condition, identify whether the resident has any concerns, and see if the resident is sleeping, needs toileting assistance, etc. Resident # 1 was admitted to the facility with diagnosis of Metabolic Encephalopathy, Cerebral Infarction, and Diabetes. The Minimum Data Set (MDS, a resident assessment instrument) dated 08/31/2023 documented Resident #1 had severe impairment in cognition. Resident #1 required extensive assist of one in activities of daily living (ADL). A Nurse's Progress Notes by Licensed Practical Nurse #2 (LPN #2) dated 09/12/2023 at 1:15 PM documented that LPN #2 came to the floor at approximately 7:25 AM, after rounds was told by the night shift nurse that Resident #1 was in the bathroom. LPN #1 proceeded to administer medications and at around 8:15 AM, staff told them that Resident #1 was not in the unit. (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 - Minimal harm or potential for actual harm Residents Affected - Few	The Incident/Accident Form dated 09/12/2023 documented at 8:24 AM charge nurse reported that Resident #1 was missing from the unit. Code E (facility's code for elopement) was activated. The Facility Investigation Summary dated 09/12/2023 at 8:30AM documented facility was searched, including every units, and outside premises. Resident #1 was not located. 911 was called and the Police Officer took Resident #1's information. At 3:30PM, the facility received a call from the precinct stating that Resident #1 was located. Resident #1 was not in any distress and was not harmed. A review of the facility's video surveillance camera revealed that on 09/12/2023 at 7:04 AM, Resident #1 was observed opening their room door and looked left and right in the hallway. At 7:10 AM, Resident #1 left their room wearing black jacket and black pants and walked in the hallway towards the back door. At 7:15 AM, Resident #1 was observed in the back yard. They walked towards the gate, went behind the trash compactor, and disappeared from camera view. The camera did not show Resident #1 exiting through the gate. During an interview on 09/18/2023 at 10:53 AM, Certified Nursing Assistant #2 (CNA #2) stated that they came to work on 09/12/2023 at approximately 7:20 AM. CNA #2 stated they made their rounds and checked each resident's room and did not see Resident #1. CNA #2 stated that LPN #1 came right behind them and was talking to LPN #2 who told them they last saw Resident #1 in the bathroom. CNA #2 stated they did not check Resident #1's bathroom, instead they went to provide care to other residents to get them up for breakfast. During an interview on 09/15/2023 at 11:24 AM, LPN #2 stated they arrived on the unit at 7:25 AM. LPN #2 stated they made their rounds and did not see Resident #1 in their room. LPN #2 stated that they spoke with LPN #1 who worked the overnight shift who informed them that Resident #1 was in the bathroom. LPN #2 stated they did not check the bathroom. At approximately 8:00 AM, LPN #2 stated Resident #1 was not in their room when they went to serve breakfast. LPN #2 stated that they did not find Resident #1 during search and notified the nursing supervisor. During an interview on 09/15/2023 at 12:30 PM, Security Guard #1 (SG #1) stated they worked at the front desk on 09/12/2023 and did not see Resident #1 exiting the back door. SG #1 stated that the back door alarm is triggered only when a resident with a wander alert device pushes the bar. SG #1 stated that they did not hear and notice any alarm going off from the back yard gate. During an interview on 09/18/2023 at 10:24 AM, the Assistant Director of nursing (ADON) stated they were responsible for investigating Resident #1's elopement. The ADON stated that Resident #1 was last seen by the night nurse at approximately 7:00 AM in their room. The ADON stated that the staff realized that Resident #1 was missing when Resident #1 did not show up at the dining room during breakfast. The ADON stated that Resident #1 was found on 09/12/2023 at approximately 3:00PM to 3:30PM. The ADON stated that each staff member is responsible for their residents' whereabouts. The ADON stated that residents are visually monitored. The ADON stated that all staff members in the facility are responsible for monitoring the resident to ensure their safety. During an interview on 11/09/2023 at 12:23PM, the Director of Nursing (DON) stated that it is the ADON's responsibility to investigate Resident #1's elopement. The DON stated that the incoming nurse should have made sure that they visually check each resident on the unit when they arrive on the floor. (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 09/21/2023 at 3:39 PM, the Administrator stated they were made aware of Resident #1's elopement on 09/12/2023 at approximately 8:45AM. The Administrator stated that all staff members must monitor residents on the unit to know their whereabouts. 10 NYCRR 415.12 (h) (2)