STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335161	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Daleview Care Center	574 Fulton Street East Farmingdale, NY 11735

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 - 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** 50429 Based on observation, interviews, and record review during an abbreviated survey with complaint # NY00350920, the facility did not ensure that the environment remained secure and free from accident hazards for one (Resident #1) of three residents reviewed for elopement. Specifically, Resident #1 with severe impaired cognition and assessed as an elopement risk exited the facility undetected by staff through an unalarmed south stairwell emergency exit door at 5:55PM. Resident #1 was found by local law enforcement 0.2 miles away from the facility at 6:40PM. The facility staff identified Resident #1 missing at 8PM. There are 12 other residents identified as elopement risk. The findings are: The facility's policy and procedure titled Elopement and Prevention effective 10/1/2005 and revised on 5/15/24 documented that it is the policy of the facility to provide safe and secure environment for all residents. In the event of resident elopement, it is the policy of the facility to implement the policy and procedure immediately to locate the missing resident in a timely manner. The policy will also be used to train and maintain staff awareness of the importance of resident safety and security. The facility's policy and procedure titled Wander Guard with effective date 10/2008 and revised on 11/2023 documented that Licensed staff to monitor residents for need to wear transmitter, based on resident assessment and risk of elopement. Use prior history of and/or observations. Ensure the care plan and the Certified Nursing Assistant accountability sheet reflect transmitter use. Ensure that residents have transmitters in place and that Certified Nursing Assistant or Nurse check for proper placement and signs of skin irritation or discomfort caused by transmitter band. Documents in medical record the placement of the alarm. Certified Nursing Assistant to report observations of wandering residents to the unit manager or supervisor. All attempts by a resident attempting to elope shall be reported immediately to the Unit manager or Supervisor. Resident #1 was admitted to the facility with diagnoses including Fall and neck pain, Acute Rhabdomyolysis, Urinary Tract Infection, Anxiety Disorder with behavioral issues, Vascular Dementia and Metabolic Encephalopathy. The Minimum Data Set, dated dated dated [DATE] identified the Resident #1's cognitive status as severely impaired, with a Brief Interview Mental Status Score of 5. Resident #1 required supervision to total assistance with activities of daily living. The Elopement Risk assessment dated [DATE], documented Resident #1 was at risk for elopement. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335161	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Daleview Care Center	574 Fulton Street East Farmingdale, NY 11735

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 - Some	The Behavior Symptoms: Wandering Care Plan initiated on 8/8/24 documented that Resident #1 was noted with exit seeking behavior, elopement assessment done, and wander guard placed on right hand. Interventions noted in place that included administer medications as ordered by physician. Ensure proper placement of right-hand wander guard and check for any malfunction. Notify MD and refer resident for psychological services as needed. Regularly assess and evaluate risk for elopement. Physician's Orders dated 8/8/24 documented an order for Wander guard - Check every shift for placement and location of device to right hand. Treatment Administration Record (TAR) on 8/8/24 initiated wander guard to right hand and to check for placement every shift. The nurses' documented for 3-11 and 11-7 shifts with their initials. On 8/9/24 the nurses documented for all 3 shifts and on 8/10/24 the nurses documented for the 7-3 and 3-11 shifts. The Certified Nursing Assistant (CNA) Accountability Record dated 8/10/24 showed Certified Nursing Assistant #2 documented a dash (-) for the 3-11 shift. The legend showed the dash (-) represented as Not Documented. The checking for wander guard function was done on 11-7 shift, nurses documented on 8/8/24 and 8/9/24. A facility Investigation Summary dated 8/10/24 documented that on 8/10/24 at 7:30 PM, Licensed Practical Nurse #1 noted that Resident #1 was not in their room and nearby hallway. Licensed Practical Nurse #1 immediately alerted floor staff to search the unit for Resident #1. A head count was conducted. At 8 pm the resident was not located, and the nursing supervisor was informed and announced, Code Orange (missing resident). The staff were assigned to search the entire building, immediate property, and the local community but the search was unsuccessful. Nursing supervisor called 911 to report elopement. At approximately 9 PM, a local law enforcer arrived at the facility and informed the nursing supervisor that Resident #1 was located and was transported to the hospital for evaluation. The nursing supervisor called the hospital and was informed that Resident #1 appeared uninjured and was expected to return to the facility. A review of surveillance cameras conducted on 8/20/2024 revealed that on 8/10/2024 Resident #1 left the dining room at about 5:40 PM. At 5:41 PM Resident #1 was seen entering the opened elevator. Resident exited the elevator in the basement level and walked towards the rear of the building and exited from the first-floor south stairwell emergency exit door into the parking lot at 5:55 PM. Resident #1 is seen walking towards the main street and out of camera range by 5:56PM. The facility is located on a 4-lane high traffic street. There is no documented progress note from the unit nurse on 8/11/2024 regarding an incident. The Nursing Supervisor Nurse's Progress notes dated 8/11/24 documented that they were informed by staff that Resident #1 was missing at approximately 8PM. Initiated unit search, unable to locate resident. Code orange was activated and every resident on the floor was accounted for. Resident #1 was unable to be found in the facility. Police were made aware. The police arrived at the facility and informed the staff that the Resident #1 was at the Hospital for evaluation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335161	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Daleview Care Center	574 Fulton Street East Farmingdale, NY 11735

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 - Some	Doctor's Progress Notes dated 8/12/24 documented that Resident #1 admitted to the hospital after an elopement incident. Psychiatry Consults dated 8/15/24 documented a Mental Status Exam, Resident #1's mood and affect were normal. No suicidal or homicidal ideation or plans, denied hallucinations, has limited though acceptable memory, cognition, insight, and judgement. No evidence of impulsivity. During an interview with Certified Nursing Assistant #2 on 8/26/24 at 10:43 AM stated that they were assigned to Resident #1 for 3-11 shift on 8/10/24. Resident #1 was assisted to the bathroom before dinner time. At approximately 7:30-7:45 PM they were informed that Resident #1 was missing. Certified Nursing Assistant #2 started the search inside the facility and the neighborhood but was unsuccessful. Certified Nursing Assistant #2 also added that wander guard placement was checked by the nurses every shift and if a resident with wander guard passed by the elevator it sets off the alarm and everyone responds to that alarm. Certified Nursing Assistant #2 also stated that they left the Certified Nursing Assistant accountability record blank when documenting for care provided for Resident #1 for that shift since Resident #1 was not in the building. During an interview with Licensed Practical Nurse #1 on 8/20/2024 at 3:20 PM stated they were working that evening shift and at around 7:30 PM they assisted Resident #1's roommate to bed when they noticed that Resident #1 was not in their bed. Licensed Practical Nurse #1 asked staff about resident #1's whereabouts but they also did not see Resident #1. They called the nursing supervisor and informed them that Resident #1 was missing. Nursing Supervisor alerted all staff and started the search but Resident #1 was not found. Later the nursing supervisor informed the staff that Resident #1 was found by the police. Licensed Practical Nurse #1 stated that they checked Resident #1's wander guard around 3PM when Resident #1 passed by the unit's elevator, and it activated the elevator's alarm. The last time they saw Resident #1 was when they gave them their 5 PM medicine. Licensed Practical Nurse #1 further added that the nurses monitored the hallway while giving the residents medication and the residents who were high risk for elopement stayed in the dining room with one Certified Nursing Assistant watching them. During an interview with Unit Manager on 8/20/24 at 11:40 AM, the Unit manager stated that on 8/8/24 Resident #1 walked and attempted to get on the unit's elevator, an elopement risk assessment was completed, and wander guard was placed on Resident #1's right wrist. They stated that they were not working that day of the incident but received a call around 9PM that Resident #1 had eloped but was found by the police at a convenient store and was brought to the hospital. During an interview and tour with Director of Maintenance on 8/20/24 at 1:45 PM they stated that the first-floor emergency exit door next to the kitchen where Resident #1 exited had no alarm and that door was used by staff and delivery personnel. If the resident with a wander guard attempts to get on the elevator, the elevator locks and alarm goes off until staff placed the code to deactivate it. During an interview with Director of Nursing on 8/20/24 at 2:40 PM they were made aware of the incident around 8:35-8:40 PM that Resident #1 was missing, and an expanded search was done, and law enforcement was called. Resident #1 exited through the side back emergency exit door that was not alarmed. Around 9PM Resident #1 was located by police and was taken to the hospital. Director of Nursing stated that Resident #1's wander guard was found in the dining room and was intact. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335161	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Daleview Care Center	574 Fulton Street East Farmingdale, NY 11735

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 - Some	During an interview with the Administrator on 8/20/24 at 3PM, stated that at 8:35 PM they were informed that Resident #1 was missing, code orange was announced and the search for Resident #1 was started but unsuccessful, then 911 was called. They were on their way to the facility when the Assistant Director of Nursing called and reported that Resident #1 was located by the police and taken to the hospital. 10 NYCRR 415.12(h)(2)