STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335347	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morris Park Rehabilitation and Nursing Center	1235 Pelham Parkway North Bronx, NY 10469

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** 39365 Based on observation, record review, and interviews conducted during an Abbreviated Survey (NY00340915), the facility failed to ensure that a resident received adequate supervision to prevent an elopement. This was evident in one out of six residents sampled (Resident #1). Specifically, Resident #1 exited the facility on 05/01/24 at 4:22 pm undetected by staff. Facility staff became aware at 7:10 pm that Resident #1 was missing. According to staff, dinner was served between 5:00 pm and 6:00 pm and they were unaware that Resident #1 was missing. Resident #1 was found by a facility staff member on 05/05/24 at around 4:55 pm at a bus stop and was brought back to the facility. Resident #1 had no visible injuries but was sent to the hospital for a wellness check. The findings are: The facility's Policy titled Wandering and Elopement, last reviewed date 11/20/23, documented that the policy of this facility is to ensure that residents will be maintained in a safe and secure manner and protected from any harm. The facility will make every effort to identify residents with potential for elopement. If a resident is discovered to be missing, a search and rescue operation will commence immediately. The facility's Policy titled Security Risk Management Plan, last reviewed on 10/20/20, documented that it is the policy of the facility to protect all residents from accidents and incidents related to unsupervised exit. The facility will always maintain and provide a safe and secure environment. Resident #1 was admitted to a facility with diagnoses that include Bipolar Disorder, Psychotic Disorder, and Depression. The Minimum Data Set Assessment (a resident assessment tool) dated 12/04/23 documented that Resident #1 had a Brief Interview of Mental Status (used to determine attention, orientation, and ability to recall information) score of 9 out of 15 associated with moderately impaired cognition. An Elopement /Wandering Risk assessment dated [DATE] documented that Resident #1 was not at risk for elopement. (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	A Nursing Progress Note, written by Registered Nurse Supervisor #1, dated 05/01/24 at 08:11 pm, documented that Registered Nurse Supervisor #1 was notified at 7:10 pm that Resident #1 was not on the unit and Code E (code for missing resident) was activated. Staff searched all units. Resident #1 was last observed at around 4:00 pm wearing a green shirt and dark pants. Staff was deployed to search outside and neighboring streets. The Director of Nursing and police were notified. The police came and collected the necessary information. A facility surveillance camera recording showed that on 05/01/24 at 4:22:08 pm, Resident #1 approached the lobby area and sat (for 17 seconds) in a chair across from the security desk. Resident #1's back was to the exit door in the lobby. Security Guard #1 was on a telephone (Security Guard #1 said they answered a facility phone call) while looking towards the lobby exit door, but away from Resident #1's direction. A pharmacy delivery person (identified by the Administrator) walked past the Security' desk and exited the facility (Security Guard #1 buzzed the door open). Resident #1 got up from the chair, walked towards the exit door, and walked out behind the pharmacy delivery person before the door automatically closed. Resident #1 was wearing a long dark coat (well dressed). A Facility Investigation Summary dated 05/01/24 documented at 7:10 pm the nurse reported that Resident #1 was not observed on the unit. Code E was activated. Resident #1 was last seen on the unit at the nursing station at around 4:00 pm wearing a green shirt with a collar and dark pants. Facility investigation concluded that abuse, neglect, or mistreatment did not occur. A Nursing Note dated 05/05/24 at 8:06 pm documented that Resident #1 arrived in the facility at approximately 6:10 pm with staff. Resident #1 ambulated freely, was alert, and verbally responsive. Resident #1 was assessed with no visible injury and vital signs within normal limits. Resident #1 was transferred to the hospital for a wellness check. During an interview on 05/07/24 at 12:30 pm, Resident #1 stated that they had just decided to visit their friends in [NAME] and was not aware they needed permission to leave the facility. During an interview on 05/07/24 at 1:00 pm, the Recreation Leader stated that they assisted with collecting the dinner trays on 05/01/24 between 5:00 pm and 6:00 pm. The Recreation Leader stated there was a dinner tray on the table that was half-covered and that there was no ticket on the tray. The Recreation Leader stated that they did not verify whose tray it was and did not check to see if the food was untouched. During an interview on 05/07/24 at 1:16 pm, Resident #1's assigned Certified Nurse Assistant #1 stated they last saw Resident #1 between 3:40 pm and 4:00 pm in the day room watching Television. Certified Nurse Assistant #1 stated that Resident #1 was not at risk for elopement and was not on any monitoring. Certified Nurse Assistant #1 stated that they fed residents in their rooms and did not know if Resident #1 ate in the dining room. Certified Nurse Assistant #1 stated when into the dining room, all trays were collected from the tables, and no one told them that Resident #1 did not eat. (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 05/07/24 at 2:10 pm, Security Guard #1 stated that they knew Resident #1 and that Resident #1 often sits in the lobby with no attempts to leave the facility. Security Guard #1 stated that on 05/07/24 they did not see Resident #1 sitting in the lobby. Security Guard #1 stated they remembered buzzing out the pharmacy delivery person but did not see Resident #1 exiting the facility. Security Guard #1 went on to say that they were on the phone answering a call to the facility. Security Guard #1 stated that their responsibility is to sign visitors in but not out. Security Guard #1 stated that the residents need a pass to leave the facility. During an interview on 05/07/24 at 2:40 pm, Certified Nurse Assistant #2 stated that they handed out trays to the tables in the dining room between 5:00 pm and 6:00 pm. Certified Nursing Assistant #2 stated that they called Resident #1 to come to the dining room but did not verify if Resident #1 was in the dining room. Certified Nurse Assistant #2 stated they went to feed residents in their room and did not know Resident #1 was not in the dining room. Certified Nurse Assistant #2 stated that when they came to the dining room, Resident #1's tray was already picked up from the table. Certified Nurse Assistant #2 stated sometime after 6:00 pm (not sure about the time) they were conducting rounds and observed that Resident #1 was not in their room. Certified Nursing Assistant #2 stated that they searched the unit and Resident #1 was not found and they immediately notified Licensed Practical Nurse #1. During an interview on 05/07/24 at 3:43 pm, Licensed Practical Nurse #1 stated that Resident #1 was not at risk for elopement, was not on visual monitoring, and did not voice a desire to leave the facility. Licensed Practical Nurse #1 stated that they saw Resident #1 sometime after 4:00 pm (not sure of the time) at the nursing station, sitting in a chair and wearing something black. Licensed Practical Nurse #1 stated at approximately 7:00 pm, the staff was asking for Resident #1, and Resident #1 was not in the unit. Licensed Practical Nurse #1 stated they called Registered Nurse Supervisor #1. Licensed Practical Nurse #1 stated that Code E was called immediately, and the staff searched inside and outside of the facility, and Resident #1 was not found. During an interview on 05/07/24 at 4:23 pm, Registered Nurse Supervisor #1 stated that they were called at 7:10 pm by Licensed Practical Nurse #1, who stated that Resident #1 was not observed on the unit. Registered Nurse Supervisor #1 stated that they were told that Resident #1 was last seen in the hallway after 4:00 pm. Registered Nurse Supervisor #1 stated the staff should have known that Resident #1 did not eat their meal during dinner and that Resident #1 was not on the unit. Registered Nurse Supervisor #1 stated that they activated Code E, a head count was done on all units, and the staff searched outside, and neighboring streets, but Resident #1 was not found. Registered Nurse Supervisor #1 stated it was noted during the investigation that Certified Nurse Assistant #2 served Resident #1's tray, and the Recreation Leader picked up the tray. Registered Nurse Supervisor #1 stated that staff should have verified that Resident #1 did not eat and report it to the nurse. (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 05/08/24 at 4:45 pm, the Director of Nursing stated that they were notified about the incident at around 7:10 pm and came to the facility. The Director of Nursing stated they investigated the incident and reviewed the facility surveillance camera recording, and it showed that Resident #1 left the faciity on [DATE] at 4:22 pm behind a pharmacy delivery person, and the Security Guard did not stop them. The Director of Nursing stated that the staff should have looked for Resident #1 during dinner time, which was between 5:00 pm and 6:00 pm. The Director of Nursing went on to say the staff did not notice that Resident #1 did not eat their dinner, and the Recreation Leader collected Resident #1's tray and did not notify anyone that the tray was untouched. The Director of Nursing stated a staff drove by the bus station on 05/05/24 and saw Resident #1, who stated they were returning to the facility. The Director of Nursing went on to say that Resident #1 was returned to the facility and was assessed without injuries. Resident #1 was transferred to the hospital for a wellness check. The Director of Nursing stated that the investigation concluded that abuse, neglect, or mistreatment did not occur. During an interview on 5/8/24 at 3:00 pm, the Administrator stated that they were notified immediately by the Director of Nursing, and they drove to the facility and observed the search was already in progress. The Administrator stated that they reviewed the camera and saw that Security Guard #1 buzzed out a pharmacy delivery person, and Resident #1 went out behind them. The Administrator stated that Security Guard #1 was supposed to stop the resident for identity. The Administrator stated that they sent a copy of the camera to the security company, and they questioned Security Guard #1, who had no idea that Resident #1 left the faciity on [DATE] at 4:22 pm. Immediate Jeopardy was not identified. Facility Past Noncompliance was identified on 05/07/24. Based on the following corrective actions taken, there was sufficient evidence that the facility corrected the Past Noncompliance and was in substantial compliance with this specific regulatory requirement prior to the surveyor's onsite visit on 05/07/24. The facility was back in compliance on 05/05/24. The facility implemented the following corrective action prior to surveyor's entrance on 05/07/24: The facility investigated the elopement and concluded that abuse, neglect, or mistreatment did not occur. The facility developed an action plan which includes the following: The police were notified and responded to the facility on [DATE]. On 05/01/24, an elopement care plan was implemented for Resident #1 with interventions to prevent elopement. The facility started re-in-servicing all staff members on 05/01/24 (ongoing). Lesson Plan: new/revised policies, policy on elopement, whereabouts log, monitoring/supervision, door openings. Visitors check/in/out electronically. On 05/01/24, the facility reviewed/revised its Elopement policy to include a whereabouts log and visitors check-in/out electronically. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/02/24, the facility created a new Policy and Procedure titled Were About Log. On 05/02/24, the facility created a new Policy and Procedure titled Wandering Elopement Risk Log Criteria. On 05/03/24, Security Guard #1 was terminated. On 05/02/24, a Quality Assurance Meeting was held. The title of the meeting was Elopement Incident. The Director of Nursing, Human Resources, Supervisors, and other department heads. An audit tool titled Accident/Supervision was developed and implemented on 05/05/24. The audit will be done weekly on all new admissions after any attempted elopement and elopement. Audits will be done by nursing supervisors. The audit tool also has a form with a questionnaire for staff members. Resident #1 was located by facility staff and brought back to the facility on [DATE], transferred to the hospital, and was found to be without injuries. On 05/05/24, the Interdisciplinary Team met with Resident #1. Education provided on leaving the facility without permission. On 05/05/24, Resident #1 was reassessed and was placed on 30 minutes monitoring. It is documented that Resident #1 agreed to wear a wander-guard and that the wander-guard will alarm when Resident #1 is close to exit door to alert both Resident #1 and staff. On 05/05/24 the elopement care plan was updated upon Resident #1's return to the facility. The facility has 179 staff, of which 92.2% were in-serviced by the Director of Nursing, Assistant Director of Nursing, and supervisors. 4 out of 4 Security Guards in-serviced 62 out of 65 Certified Nursing Assistants in-serviced 4 out of 4 Home Health Aides 20 out of 21 Licensed Practical Nurses in-serviced 15 out of 17 Registered Nurse Supervisors in-serviced 7 out of 8 Recreations staff in-serviced 20 out of 23 Housekeeping and maintenance staff in-serviced 17 out of 20 Dietary staff in-serviced 2 out of 2 Social Services in-serviced 6 out of 7 Administration staff in-serviced (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8 out of 8 Physical Therapist/Occupational Therapist in-serviced. The Director of Nursing/designee will contact the remaining 7.8% of staff for in-servicing prior to their return to work or returning to units. 10NYCRR 415.12(h)(1)(2)