STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335415	A. Building B. Wing	02/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence Nursing Care Center, Inc	350 Beach 54th Street Arverne, NY 11692

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. 39365 Based on observation, record review, and interviews conducted during an Abbreviated Survey (NY00332082), the facility did not ensure that Resident #1 received adequate supervision. This was evident in one of the seven residents sampled (Resident #1). Specifically, on 01/23/24 at 06:24 PM, Resident #1, whose cognition was moderately impaired, left the building for four hours and 21 minutes before staff realized that Resident #1 was missing from the unit. A review of the facility's camera footage showed that Resident #1 exited through the facility's main entrance door on 01/23/24 at 6:24 PM. Security Guard #1 was sitting at the front desk, buzzed the door open, and Resident #1 exited the door. The findings are: The facility's Policy and Procedure, entitled Resident Elopement Policy and Procedure, last reviewed on 10/22, documented that it is the policy of the facility that residents will be maintained in a safe and secure manner and protected from actual harm while encouraging a restrain-free environment. This document also documented that all visitors and vendors must sign in and out at the security desk. Resident #1 was admitted to the facility with diagnoses including Adjustment Disorder, Alcohol Abuse, and Atrial Fibrillation. A Minimum Data Set (a resident assessment tool) dated 01/05/24, documented that Resident #1 had moderately impaired cognition. A facility's surveillance camera recording, dated 01/23/24, showed that Security Guard #1 buzzed Resident #1 out of the facility's front door in the main lobby at 05:24 PM (real-time 6:24 PM). A Safety Check sheet dated 01/23/24, documented that Resident #1 was on the nursing care unit at 06:30 PM. Every half-hour entry on the Safety Check sheet from 07:00 PM to 11:00 PM, documented that Resident #1 was sleeping. (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 Nurse's Progress Note written by Registered Nurse Supervisor #1, dated 01/24/2024 at 02:35 AM, documented at 10:55 PM, Security Guard #1 on duty notifying the staff about a missing person. Residents' head counts were done, searching was conducted on all the units, closets, toilets, stairs, the garage, and the surrounding environment. Staff could not find Resident #1. The Director of Nursing, the Administrator, the Assistant Director of Nursing, and the Medical Doctor were notified. The emergency system was activated for elopement/ missing person. A Medication Administration Documentation Audit Detail Report 01/23/24, documented that Resident #1 received Lipitor 20 milligrams for Hyperlipidemia at 08:24 PM. A facility's investigation dated 01/23/24, documented at approximately 10:45 PM, Certified Nursing Assistant #2 became aware Resident #1 was not in their room. Code Missing Person was called, and a facility-wide search was initiated with no success. As per Certified Nursing Assistant #1, Certified Nursing Assistant #2, and Licensed Practical Nurse #1 interviews, Resident #1 had dinner, took their medications, and went to their room. Resident #1 was last seen in their room at 5:30 PM by Certified Nursing Assistant #1. The Director of Nursing was notified at 11:00 PM, and the Administrator was notified at 11:15 PM. At 1:25 AM, the police responded to the 911 call. On 01/24/23 at approximately 11:30 AM, the police notified the facility that Resident #1 was found in their apartment and was taken to the Hospital emergency room for evaluation. During an interview on 01/29/24 at 1:22 PM, Certified Nursing Assistant #1 stated that Resident #1 was seen between 5:30 PM and 6:30 PM in the dining room, ate their dinner, and walked out of the dining room. Certified Nursing Assistant #1 stated that at 7:00 PM, when they went to Resident #1' s room to bring a snack, the bathroom door was closed. Certified Nursing Assistant #1 stated that they thought that Resident #1 was in the bathroom and told them that they brought a snack. Certified Nursing Assistant #1 stated that they did not hear an answer but thought they heard a sound, and they left without visually checking if Resident #1 was in the bathroom. Certified Nursing Assistant #1 stated that they did not do rounds and did not sign the 30-minute safety sheet after 7:00 PM. Certified Nursing Assistant #1 stated that close to the end of 3:00 PM -11:00 PM shift, Certified Nursing Assistant #2 told them that Resident #1 was not in their room, and they went to search for Resident #1. During an interview on 01/29/24 at 3:46 pm, Certified Nursing Assistant #2 stated that they were assigned to Resident #1 on 01/23/24 for the 3 PM -11 PM shift. Certified Nursing Assistant #2 stated that Resident #1 was alert and was never seen wandering nor heard stated that they wanted to leave the facility. Certified Nursing Assistant #2 stated that they do not remember if Resident #1 had any scheduled visual monitoring, but they did monitor all resident to make sure that all residents were well. Certified Nursing Assistant #2 stated that the last time they saw Resident #1 was at dinner time, around 5:00 PM -5:15 PM. Certified Nursing Assistant #2 stated that they served Resident #1 dinner, Resident #1 ate, sat for a while, and went to the hallway leading to their room. Certified Nursing Assistant #2 stated that they did resident monitoring between 6:30 PM and 7:00 PM and did not see Resident #1 in their room or in the dining room. Certified Nursing Assistant #2 stated that they did not notify the nurse because they thought Resident #1 was in the bathroom. Resident monitoring was done at approximately 10:00 PM -10:30 PM and did not see Resident #1 in the room, the bathroom, or on the unit. They asked a coworker if they saw Resident #1 and told the Registered Nurse #1 that Resident #1 was missing. Certified Nursing Assistant #2 stated that the Nursing Supervisor #1 was called, and they searched the building. Certified Nursing Assistant #2 stated that they did not sign the monitoring sheet every 30 minutes on 01/23/24 after 06:00 PM. (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 01/29/24 at 6:42 pm, Certified Nursing Assistant #3 stated that they were not assigned to Resident #1 but last saw Resident #1 at around 5:30 PM in the dining room. Certified Nursing Assistant #3 stated that Resident #1 was on every 30-minute monitoring. All Certified Nursing Assistants on the unit were responsible for visually checking the residents and documenting the residents whereabouts. Certified Nursing Assistant #3 stated they did not sign the Safety Check sheet on 01/23/24 from 7:00 PM to 11:00 PM. During an interview on 01/29/24 at 5:53 PM, License Practical Nurse #1 stated that Resident #1 was given their medication at 05:30 PM but documented in the medication administration record at 08:24 PM. Licensed Practical Nurse #1 stated that they forgot to inform the Physician that the medication schedule needs to be changed. Resident #1 preferred to have their medications early evening and not be disturbed when sleeping. Licensed Practical Nurse #1 stated that at around 10:45 PM, Certified Nurse Assistant #2 said they could not find Resident #1. Licensed Practical Nurse#1 stated that they searched the unit and did not see Resident #1 Licensed Practical Nurse #1 stated that they called a Nursing Supervisor #1 and security to announce the code for a Missing Person. Licensed Practical Nurse #1 stated that Certified Nursing Assistants were responsible for doing visual checks of Resident #1, who was on every 30 minutes monitoring for safety and documented on the safety sheet. Licensed Practical Nurse #1 stated that Certified Nursing Assistant #1 said that at 07:00 PM, when giving out snacks they thought that Resident #1 was in the bathroom, and they did not visually see Resident #1. During an interview on 01/30/24 at 10:18 AM, Registered Nurse Supervisor #1, who worked on 01/23/24 11:00 PM-7:00 AM shift, stated that they were notified that Resident #1 was missing on 01/23/24 at approximately 10:55 PM. Registered Nurse Supervisor #1 stated that they heard the Security Guard #1 paged overhead twice for a missing person. The emergency system was called and responded. Registered Nurse Supervisor #1 stated that they initiated an investigation and interviewed all staff on the unit and the Security Guard #1. During an interview on 01/30/2024 at 10:33 AM, Security Guard #1 stated that they were on duty on 01/23/24 from 4:00 PM to 12:00 PM, just before 07:30 PM while doing multiple tasks, a person came to the exit door, dressed as a visitor, and did not come to the desk to sign out in the log. Security Guard #1 stated that there was a Social Worker #1 at the front desk. Security Guard #1 assumed that if it was a resident, the Social Worker would say something. Security Guard #1 stated that the Social Worker did not say anything, and they let the person out by pressing the button to unlock the door. Security Guard #1 stated that they had never seen Resident #1 before, and their picture was not at the front desk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 01/30/24 at 12:15 PM, the Director of Nursing stated that Registered Nurse Supervisor #1 notified them that they could not locate Resident #1. The Director of Nursing stated that they notified the Administrator immediately and both came to the facility immediately. The Director of Nursing stated that they reviewed the video camera with the Administrator and saw that Security Guard #1 let Resident #1 exit the facility by buzzing them out. The Director of Nursing stated that Security Guard #1 did not make sure that Resident #1 signed out in the visitor book and buzzed Resident #1 out of the facility. There was a Social Worker #1 at the front desk who denied seeing Resident #1 exiting the facility. The Director of Nursing stated that they investigated the incident. Resident #1 was not at risk for elopement, and they did not know the reason Resident #1 was on every 30-minute monitoring. The Director of Nursing stated that if residents are on scheduled visual monitoring, the assigned Certified Nursing Assistant should carry the monitoring sheet with them, visually check the resident's whereabouts, and document it. The Director of Nursing stated that they don't recognize who signed the Safety Check for Resident #1 on 01/23/24 from 07:00 PM to 11:00 PM. During an interview on 01/29/24 at 06:51 PM, the Administrator stated that the Certified Nursing Assistant #1 assigned to Resident #1 was responsible for visually checking and documenting on the monitoring sheet. The Administrator stated that staff on the unit failed to properly monitor Resident #1. The Security failed to check the identity or allow Resident #1 to sign out before exiting the building. The Administrator stated that they did not have a policy for visual monitoring. 10NYCRR 415.12(h)(1)(2)