

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335448	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2023
NAME OF PROVIDER OR SUPPLIER Queens Nassau Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 520 Beach 19th Street Far Rockaway, NY 11691	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39365</p> <p>Based on observation, interviews, and record review during an abbreviated and partial extended survey (NY00322953), the facility failed to ensure a resident, identified as an elopement risk and had a history of previous elopement, received adequate supervision to prevent elopement from facility. This was evident in 1 of 5 residents sampled (Resident #1). Specifically, on 08/29/2023, Resident #1, who was cognitively impaired and had a wander alert device in place, left the building undetected. Resident #1 returned to the facility from a clinic appointment on 08/29/2023 at 3:42 PM. There was no documented evidence that Resident #1 was monitored by staff every 15 minutes, as an intervention to prevent elopement, after 3:45 PM on 08/29/2023. Subsequently, Resident #1 was identified missing at 5:40 PM. This resulted in no actual harm with likelihood for more than minimal harm that is Immediate Jeopardy and substandard quality of care to resident health and safety.</p> <p>The findings are:</p> <p>The facility policy titled Elopement of Resident with review date of 10/2020 stated that it is the policy of the facility to prevent and manage elopement attempts that may occur with residents. All residents are assessed for elopement risk on admission, quarterly, and as needed.</p> <p>The facility policy titled Missing Residents with review date of 02/2018 stated that it is the policy of the facility to ensure the safety and security of residents, staff, and visitors. The process for locating and recovering a lost or missing resident from the facility will include but not be limited to coordination with law enforcement agencies. The procedure states that staff will record the time that the resident becomes missing, including when and where they were last seen. Staff will verify that the resident has not signed out with family. A Code C (code for elopement) will be announced.</p> <p>Resident #1 was admitted to the facility with diagnoses of Traumatic Brain Injury (a serious condition that affects brain's function due to a sudden impact) and Mood Disorder (a mental health condition with long periods of extreme happiness, extreme sadness, or both). The Minimum Data Set (MDS, a resident assessment tool) dated 07/17/2023 documented that Resident #1 is severely cognitively impaired. The MDS documented that Resident #1 had a history of wandering.</p> <p>A Wandering /Elopement Risk assessment dated [DATE] documented that Resident #1 was at risk for elopement.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A Comprehensive Care Plan (CCP) on elopement risk was initiated for Resident #1 on 02/13/2023. The facility interventions included ongoing assessment with 15-minute monitoring to Resident #1's location and a wander alert device. The care plan notes documented on 03/07/2023, at risk for elopement, seeking out first floor exits, wander alert device was applied to left ankle. On 04/22/2023, Resident pushed through back door attempted to elope through the ambulance door, was returned by nurse. On 05/19/2023, status post elopement from the clinic. And on 08/29/2023, around 4:00 PM, Resident left the facility unescorted.</p> <p>A Resident Nursing Instruction (a care plan instruction for Certified Nursing Assistants) dated 03/07/2023 documented safety precaution: Elopement; wander alert device to the left ankle; check placement of wander alert device to left ankle every shift; and every 15-minute monitoring.</p> <p>The Door Alarm and Wander Guard Weekly Inspection Form documented the 3rd floor stairways, A, B and C exit doors, and elevators were properly tested , and the wander alert system was working properly on the 4th week of August. There was no indication as to what date the inspection was performed.</p> <p>A Visual Monitoring Sheet dated 08/29/2023 3-11 shift documented that Resident #1 was on 15-minute monitoring and documented Out on Pass (OOP) from 3:15 PM to 3:30 PM. The last entry on the monitoring sheet at 3:45 PM documented that Resident #1 was at the nursing station. There was no documented evidence of Resident #1's location or activities after 3:45 PM.</p> <p>A Resident Half Hour Observation Sheet dated 08/29/2023 documented from 3:00 PM to 4:30 PM that Resident #1 was OOP. There was no further documentation after 4:30 PM.</p> <p>A nursing note dated 08/29/2023 at 11:05 PM by Licensed Practical Nurse #1 (LPN #1), documented Resident #1 returned to the nursing unit at 3:45 PM from their clinic appointment.</p> <p>A nursing note dated 08/30/2023 at 12:36 AM by Registered Nurse Supervisor #1 (RNS #1), documented Resident #1 left the facility unescorted on 08/29/2023 around 4:00 PM and did not notify the staff prior to departure.</p> <p>On 09/06/2023 at 10:30 AM, the facility surveillance camera was reviewed with the Director of Nursing (DON) and the Administrator. The camera time is 10 minutes behind actual time. The surveillance camera showed on 08/29/2023 at 3:37 PM (actual time 3:47 PM), Resident #1 came to the lobby from the elevator area (the elevators were not in camera view). The Attending Physician #1 (AP #1) walked behind Resident #1. There were no other people in the lobby. Resident #1 passed by the security desk and walked towards the main entrance (the main entrance door was not visible on camera). AP #1 stopped by the security desk, threw an item in the garbage bin, and walked towards the main entrance behind Resident #1. At 3:38 PM (actual time 3:48 PM), Resident #1 exited through the main entrance with AP #1 behind them (only the corner of the door was visible). Resident #1 made a right turn on the sidewalk and disappeared from the camera view.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility's investigation summary form dated 09/04/2023 by the DON, documented Resident #1 exited the facility on 08/29/2023 at approximately 4:00 PM. Resident #1 returned from their clinic appointment at 3:45 PM accompanied by CNA #4 and was escorted to the unit nurse. The nurse did not inform the staff that Resident #1 returned to the facility. 15-minute monitoring was done only up to 3:45 PM by the nurse. The investigation summary documented that facility acknowledged that Resident #1 left the facility through the front door. The wander alert system was operational based on the last check. The facility concluded the wander alert bracelet worn by Resident #1 was faulty because the security guard stated that they did not get up to reset the system. Resident #1 returned to the facility on [DATE] at 5:15 PM accompanied by the family.</p> <p>A review of the Security Record Book dated 08/29/2023 documented Code C (facility's code for resident elopement) was called for Resident #1 at 6:00 PM.</p> <p>During an interview on 09/06/2023 at 2:00 PM, CNA #4 stated they escorted Resident #1 to their clinic appointment on 08/29/2023 and left the unit at approximately 2:58 PM. They returned to the facility at approximately 3:45 PM. They brought Resident #1 to their room and told LPN #1 that Resident #1 was back. CNA #4 stated they left the unit after speaking with LPN #1. They stated that they did not hear any alarm go off while they were on the unit.</p> <p>During an interview on 09/05/2023 at 2:41 PM, LPN #1 stated that Resident #1 was an elopement risk, had a wander alert device, and to be monitored every 15 minutes. LPN #1 stated that Resident #1 went to a clinic appointment on 08/29/2023 at 3:00 PM and returned to the unit at 3:45 PM. LPN #1 stated they documented in the 15-minute monitoring sheet that Resident #1 was on the unit. LPN #1 stated they told Resident #1 to go to their room but did not make sure Resident #1 followed the instruction. LPN #1 stated they did not inform the CNAs on the unit that Resident #1 had returned. LPN #1 stated it was their responsibility to inform the assigned CNA that Resident #1 was back and give them instructions. LPN #1 stated they did not monitor Resident #1 every 15-minutes upon return from the clinic because it was the CNA's responsibility. LPN #1 stated at approximately 5:40 PM, they were passing by Resident #1's room and noticed Resident #1's supper tray was not touched. The roommate told them they had not seen Resident #1. LPN #1 stated they did a head count and started a search on the unit, went to every floor, and the basement. LPN #1 stated when they did not find Resident #1, they called RNS #1 but does not recall the time. RNS #1 told them to continue the search and a Code C was called. LPN #1 stated during a subsequent interview on 09/07/2023 at 10:03 AM, that they did not hear any alarm go off during their shift on 08/29/2023.</p> <p>During an interview on 09/05/2023 at 1:20 PM, CNA #1 stated they arrived in the unit on 08/29/2023 at 3:00 PM and did not see Resident #1 during monitoring. CNA #1 stated they asked LPN #1 where Resident #1 was, and LPN #1 told them Resident #1 was out on a clinic appointment. CNA #1 stated while serving supper at approximately 4:45 PM, they asked LPN #1 again where Resident #1 was. LPN #1 stated Resident #1 had returned to the unit earlier. CNA #1 stated they did a head count of residents and started to search for Resident #1. CNA #1 stated that RNS #1 and Security were notified, and a Code C was announced. Staff went to different locations, to nearby buildings, and the hospital, but they were not able to locate Resident #1. CNA #1 stated they did not hear any alarm go off.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/05/2023 at 3:40 PM, CNA #2 stated they were not aware that Resident #1 came back to the unit from their clinic appointment on 08/29/2023. CNA #2 stated the nurse is supposed to let them know when a resident is back from clinic appointments. CNA #2 stated they did not find Resident #1 while serving supper at approximately 5:50 PM. LPN #1 told CNA #1 Resident #1 had been back earlier. CNA #1 stated they immediately searched for Resident #1. CNA #2 stated that they did not hear any alarm go off.</p> <p>During an interview on 09/07/2023 at 10:40 AM, CNA #3 stated they did resident monitoring at 3:00 PM on 08/29/2023 and was told by LPN #1 that Resident #1 was out on appointment. CNA #3 knew Resident #1 was at risk for elopement, had a wander alert device, and was on 15-minute monitoring. CNA #3 stated they were not aware Resident #1 was back in the unit and they did not hear any alarm go off during their shift.</p> <p>During an interview on 09/06/2023 at 4:22 PM, RNS #1 stated on 08/29/2023 at approximately 3:45 PM, CNA #4 informed them Resident #1 returned to the unit from a clinic appointment and gave them the clinic paper. RNS #1 stated after 6:00 PM, LPN #1 notified them Resident #1 was not in the unit. RNS #1 immediately went to the unit, did a search on the unit, and then called Code C.</p> <p>During an interview on 09/05/2023 at 12:51 PM, Security Guard #1 (SG #1) stated they worked on 08/29/2023 from 9:00 AM to 5:00 PM. SG #1 stated they did not see when or how Resident #1 left the facility because they were on the phone. SG #1 stated there was a shift change between 3:00 PM and 4:00 PM and there was a lot of staff traffic. SG #1 stated they did not hear an alarm sound. SG #1 stated, Maybe because the door was open otherwise the door would be locked if a person with a wander alert device approach the exit. SG #1 stated no alarm was activated, and they did not reset the wander alert system. SG #1 was aware Resident #1 was at high risk for elopement and Resident #1 had a picture at the front desk.</p> <p>During a subsequent interview with SG #1 on 09/07/2023 at 10:17 am, they stated they did not hear the alarm when Resident #1 left for a clinic appointment on 08/29/2023 at 3:00 PM and did not hear an alarm when Resident #1 returned from their clinic appointment. SG #1 did not hear an alarm when Resident #1 exited the building. SG #1 stated they do not recall resetting the alarm. SG #1 stated they do other tasks such as answering phones, distributing employee paystubs, distributing COVID-19 test kits and explain to visitors how to use the test kits. SG #1 stated the main entrance door will automatically lock when a resident with a wander alert device approached the main entrance and an alarm would go off if they tried to open the door. SG #1 stated they must physically reset the alarm on the panel at the main entrance if the wander alert alarm is triggered. SG #1 stated it is hard to hear the alarm if the phone was ringing.</p> <p>During an interview on 09/06/2023 at 11:40 AM, AP #1 stated that they do not recall Resident #1 walking near them when they were exiting the facility. They do not recall if the elevator was blocked and did not hear an alarm when they exited the facility on 08/29/2023.</p> <p>During an interview on 09/06/2023 at 6:12 PM, the Director of Maintenance (DOM) stated they conducted a daily inspection of the wander alert system for proper functioning. The DOM stated they check the wander alert system every week on Monday to make sure the wander alert system worked properly when generator turns on. The DOM stated the last time they checked the wander alert system on 08/29/2023 during morning rounds and it was functioning.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/05/2023 at 2:35 PM, the DON stated RNS #1 informed them on 08/29/2023 at around 6:20 PM that Resident #1 was missing. The DON stated according to their investigation, Resident #1 came back from a clinic appointment with CNA #4. CNA #4 returned Resident #1 to the nursing unit and told LPN #1. LPN #1 did not tell the assigned CNA or any other CNAs on the unit that Resident #1 was back and needed to be monitored every 15-minutes. The DON stated LPN #1 told them when LPN #1 passed by Resident #1's room at 5:40 PM, LPN #1 noticed Resident #1's meal tray was not touched, and Resident #1's roommate stated they had not seen Resident #1. LPN #1 started a search on the unit and notified RNS #1. A Code C was called at around 6:00 PM. The DON stated it was unknown how Resident #1, who was wearing a wander alert device, was able to use the elevator and exit through the main entrance door. The DON stated the staff did not hear any alarm go off in the lobby.</p> <p>During an interview on 09/05/2023 at 5:10 PM, the Administrator stated they were notified by the DON that Resident #1 was missing. They called SG #1 and requested they go to the facility and review the camera to find out how Resident #1 exited the building. The Administrator stated the investigation revealed LPN #1 did not notify the staff on the unit that Resident #1 returned from their appointment. They stated it is the security guard's responsibility to prevent residents from leaving the facility unescorted. The Administrator stated that the security guard should pay attention to who is leaving the facility, stop the resident from leaving, and to notify nursing if a resident is leaving without an escort. The Administrator stated they did not know what happened on the day Resident #1 exited the facility. Resident #1 was able to ride the elevator to the first floor and exit through the main entrance and no one, not even SG #1, heard the alarm. The Administrator stated that Resident #1 was smart and may have manipulated the wander alert bracelet.</p> <p>Immediate Jeopardy (IJ) was identified, and the DON was notified on 09/07/2023 at 6:00 PM. An acceptable immediate corrective action plan from the facility was received on 09/08/2023 at 1:18 AM.</p> <p>Immediate Jeopardy was removed prior to survey exit on 09/12/2023 based on the following corrective actions taken by the facility:</p> <ol style="list-style-type: none"> 1. Resident #1's care plan for elopement was reviewed and interventions were updated to include 1:1 monitoring. 2. A wander alert antenna was installed closer to the security desk that will trigger before a resident with a wander alert device reaches the main entrance. A siren and flashing light were also installed in the lobby which will get the attention of the security guard and other employees in the area. Sirens were installed on each elevator. 3. The facility implemented a policy and procedure on Wander Guard / Code Alert on 09/08/2023. The policy stated the 11:00 PM -7:00 AM nursing supervisor will be responsible for checking the functionality of the wander alert device. The unit nurse will check for placement every shift and document in the treatment administration record. 4. The security guard duties and responsibilities were modified. Clerical duties such as distributing payroll checks and COVID-19 kits were removed from their job responsibility. This allows for consistent monitoring of front door and lobby area at all times. A copy of the revised General Duties of Security Guards was signed by each security guard submitted to the DON. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>5. An Elopement Risk Drill was conducted by the facility on 09/09/2023 at 10:45 AM and 3:30 PM. The objective of the drill was to have staff demonstrate the rapid response to a Code C (code for elopement) and for staff to demonstrate an understanding of the updated Code Alert System. A copy of the drill documentation was submitted by the facility.</p> <p>6. A Quality Assurance meeting was held on 09/11/2023 by the interdisciplinary team regarding Resident #1's elopement.</p> <p>7. The facility completed staff education on Elopement Risk Prevention and Missing Resident Protocol with emphasis on informing nursing staff when a resident returns to the facility from a clinic appointment, therapeutic leave or out on pass; wander alert system; and the facility's policy and procedure on Wander Guard / Code Alert.</p> <p>The facility had 195 employees. 9 employees are on leave, on vacation, or are out on disability. As of 09/12/2023, a total of 188 employees received education. Staff interviews were conducted to verify they were educated. They were knowledgeable of the elopement protocol and the updates to the wander alert system. Staff who are out of work will attend education prior to reporting to their workstation.</p> <p>10 NYCRR 415.12(h)(2)</p>		