STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335462	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Plaza Rehab and Nursing Center	100 West Kingsbridge Road Bronx, NY 10468

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** 49081 Based on observation, record review, and interviews during an abbreviated survey (NY00356446), the facility did not ensure that each resident received adequate supervision to prevent an elopement. This was evident for one (1) out of four (4) residents (Resident #2) sampled for elopement. Specifically, the facility Elopement/Unauthorized Leave Incident Report dated 10/04/2024 documented that the surveillance video footage showed at 11:09 AM on 10/04/2024 Resident #2 exited the unit unsupervised. At 11:15 AM, the East COVID entrance door alarm was activated, and Security Officer #3 deactivated the alarm. The investigation documented that it was confirmed at 11:47 AM Resident #2 was missing. Resident #2 was located by the police and was taken to the emergency roiagnom on [DATE] without injury. The findings include: A Policy and Procedure titled Elopement and Unsafe Wandering Policy reviewed 10/04/2024 documented an elopement occurs when a resident leaves the premises or a safe area without authorization (i.e. an order for discharge or leave of absence) and/or any necessary supervision to do so. A Policy and Procedure titled Resident Safety and Security desk Operations reviewed date of 04/2024 documented monitor resident exits and ensure Out on Pass documentation is complete and residents are properly escorted. Prevent unauthorized resident undetected exit of building or unescorted departures. Monitor resident movement through entrances and exits. Prevent unauthorized exits, especially for residents with cognitive impairments. Immediately report any high-risk exit seeking residents to the director of security. Surveillance and Monitoring documented regularly check Closed Circuit Television to secure high-risk or sensitive areas throughout the facility. Resident #2 admitted to the facility with diagnoses including Dementia, Schizophrenia Disorder, and Anxiety Disorder. The Minimum Data Set (an assessment tool) dated 10/04/2024 documented Resident #2 was moderately impaired (decisions poor; cues/supervision required). Resident #2 ambulated with supervision or touching assistance. An Elopement Risk assessment dated [DATE] documented Resident #2 was identified at risk for elopement. Resident #2 had exhibited exit seeking behavior, restlessness, agitation, and verbalized desire to leave the facility. (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 Wandering/Elopement Risk Care Plan dated 10/02/2024 documented to provide visual monitoring of Resident #2's location every hour and alert staff regarding Resident #1's behavior. An Hourly Visual Check Monitoring form dated on 10/04/2024 documented other for Resident #2's location from 9:00 AM - 10:00 AM and from 10:00 AM - 11:00 AM. An Accident/Incident Investigation Report dated 10/04/2024 at 11:49 AM, documented Resident #2 was observed by the elevator approaching the nursing station. At approximately at 11:15 AM, the East lobby alarm was activated with full search of security and staff conducted headcount. At 11:47 AM, Resident #2 was not visible on the unit. Security and the Assistant Director of Nursing were notified. Code Orange (elopement code) was activated at 11:49 AM. Review of the facility Elopement/Unauthorized Leave Incident Report dated 10/04/2024, documented Timeline of Events (from Security Department). At 11:09 AM, Resident #2 exited the unit without authorization. At 11:15 AM, Security Officer #3 deactivated the triggered Code Alert box at the East COVID doors. At 11:21 AM, Security Officer #4 notified the Director of Security of triggered alarm. At 11:24 AM, the Director of Security contacted Associate Director of Nursing to initiate a full facility count. At 11:47 AM, Associate Director of Nursing confirmed that Resident #2 was missing. At 11:49 AM, Code Orange was announced. At 11:51 AM, Incident Command Center was activated. At 11:55 AM, Director of Security contacted local law enforcement. At 1:43 PM, Code Orange remained in effect until local law enforcement located Resident #2. At 1:58 PM, a notification was received via WhatsApp group chat that Resident #2 was found walking on the highway and was taken to the emergency room at approximately 1:40 PM by the police. A nursing progress note dated 10/07/22024 at 9:48 AM (late entry for 10/04/2024) by Unit Manager #1 documented Resident #2 left the facility unauthorized on 10/04/2024. Resident #2 was picked up by an ambulance and was sent to hospital. Resident #2 was discharged home from hospital with their spouse. During an interview on 04/07/2024 at 12:00 PM, Resident #2's assigned Certified Nursing Assistant #3 who worked on 10/04/2024 on the 7:00 AM to 3:00PM shift, stated they were in the hallway documenting in sigma kiosk when Resident #2 returned from their appointment and was left at the nursing station (does not recall the time). Certified Nursing Assistant #3 stated they provided Resident #2 with a wheelchair and brought them back to their room. Certified Nursing Assistant #3 stated Resident #2 did not attempt to exit the facility and did not exhibit any behavior problem on 10/04/2024. Certified Nursing Assistant #3 stated that they monitored Resident #2, and prior to them leaving for their break at 11:00 AM, they notified Registered Nurse #1 and other Certified Nursing Assistants on the unit that they were leaving the unit. Certified Nursing Assistant #3 stated when they returned from their break, the staff were searching for Resident #2. Certified Nursing Assistant #3 stated everyone knew Resident #2 was on visual monitoring for wandering behavior. (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 04/07/2025 at 12:29 PM, Registered Nurse #1 who worked on 10/04/2024 on the 7:00 AM to 3:00 PM shift stated Resident #2 did not exhibit any behaviors that would indicate they wanted to leave the facility. Registered Nurse #1 stated they gave Resident #2 their medications at 10:00 AM and Resident #2 verbalized that they did not need anything when they were asked. Registered Nurse #1 stated Resident #2 was ambulatory; walked around on the unit; and was being monitored for wandering behavior. Registered Nurse #1 stated Resident #2 had a wander guard in place on their right ankle that was functional. Registered Nurse #1 stated that the wander guard placement and functionality is documented in the Treatment Administration Record. Registered Nurse #1 stated that one of the staff members (does not recall name) asked them for Resident #2 (don't recall time) and they checked the off-unit logbook and Resident #2 was not at therapy. Registered Nurse #1 stated they instructed the staff members to search the unit and notify Unit Manager #1 if Resident #2 was not located. Registered Nurse #1 stated they do not recall the exact time, but that it was after 11:00 AM that they were unable to locate Resident #2 and Code Orange was activated. Registered Nurse #1 stated that none of the staff saw Resident #2 exited the unit via the elevator (Cab #3) located on the side of the nursing station. Registered Nurse #1 stated they did not hear the elevator alarm on the unit. An attempt was made to contact Security Officer #3 multiple times on 04/08/2025 but was unsuccessful. A letter was sent via certified mail on 04/08/2025 with no response to date. During a telephone interview on 04/08/2025 at 12:13 PM, Unit Manager #1 stated they conducted rounds and the unit (does not recall time) and spoke with Resident #2's roommate, Resident #2 was not in their room during rounds. Unit Manager #1 stated Resident #2 was on hourly visual monitoring. Unit Manager #1 stated Code Orange was announced at approximately 11:49 AM and staff conducted headcounts on all the units. Unit Manager #1 stated all staff on the unit reported they did not hear any of the alarms (exit doors and elevators) sounding on the unit. Unit Manager #1 stated they don't have any explanation as to how Resident #2 was able to leave the unit unsupervised. Unit Manager #1 stated that staff must punched in a code on the keypad before using the exit doors otherwise, the door will alarm. (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 04/07/2025 at 2:00 PM, Associate Director of Nursing stated the Director of Security notified them on 10/04/2024 at approximately 11:24 AM that the alarm went off in the East lobby main entrance at approximately 11:15 AM. The Associate Director of Nursing stated at approximately 11:47 AM, Unit Manager #1 reported to them that Resident #2 was not on the unit and that a search had been completed. The Associate Director of Nursing stated that Code Orange was activated at 11:49 AM. The Associate Director of Nursing stated that the searched was extended to neighboring area, staff was sent to different areas, hospitals were called, and the police was notified. The Associate Director of Nursing stated the hospital called the facility on 10/04/2024 at 1:58 PM and reported Resident #2 was brought into the emergency department by the police at 1:40 PM. The Associate Director of Nursing stated they went to the hospital and Resident #2 was there with their spouse and the police. The Associate Director of Nursing stated Resident #2 was assessed in the emergency department with no visible injuries. The Associate Director of Nursing stated Resident #2 was discharged from the emergency room to their home with their spouse. The Associate Director of Nursing stated Resident #2's wander guard was removed and tested in the facility and was found to be functional when the elevators wander guard alarms activated. The Associate Director of Nursing stated they don't know why the alarm on the elevator didn't active when Resident #2 entered the elevator. The Associate Director of Nursing stated they reviewed the video footage dated 10/04/2024 at 11:07 AM and Resident #2 went by the side elevator (cab #3) of nursing station and exited the elevator without sounding the alarm. The Associate Director of Nursing stated that the video footage showed three staff members were at the nursing station on the unit at the time, but they did not notice Resident #2 going to the elevator. The Associate Director of Nursing stated when a resident wearing a wander guard stands in front of the elevator, the elevator wander guard alarm will activate, and the elevator will not move unless a staff enters a code to deactivate the alarm. The Associate Director of Nursing stated Resident #2 was last seen at 11:15 AM prior to exiting the East lobby in the COVID entrance door. The Associate Director of Nursing stated Security Guard Officer #3 was not aware Resident #2 exited the facility. The Associate Director of Nursing stated after Resident #2 activated the wander guard alarm in the East lobby entrance door that leads to the street, Security Guard Officer #3 got up, checked inside the lobby, looked around the door outside, then deactivated the alarm. The Associate Director of Nursing stated Security Officer #3 did not follow facility policy protocol. Security Officer #3 should not have deactivated the alarm and should have immediately notified the Director of Security. The Associate Director of Nursing stated they investigation concluded that abuse or neglect did not occur because Resident #2 was on hourly visual monitoring and had a wander guard in place. During a telephone interview on 04/16/2025 at 12:10 PM, Security Officer #4 stated they worked on 10/04/2024 on the 7:30 AM-3:30 PM shift. Security Officer #4 stated that they were in the process of relieving Security Officer #3 when they heard an alarm sounding from the East lobby side of the COVID entrance, but the alarm stopped once they approached the lobby. Security Officer #4 stated they asked Security Officer #3 about the alarming door at the COVID entrance and Security Officer #3 told them that they reset the alarm. Security Officer #4 stated they notified the Director of Security that the exit door alarm was activated. Security Officer #4 stated they were not aware that a resident was missing unit they were notified by nursing and Code Orange activated. Security Officer #4 stated it was the Director of Security who reviewed the camera on 10/04/2024 (does not recall the time). (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 04/07/2025 at 11:40 AM the Director of Security stated they were notified by Security Officer #4 that the alarm in the East lobby side by the COVID entrance door was triggered. The Director of Security stated that Security Officer #3 should have investigated the interior and exterior perimeter to ascertain why the alarm was triggered and notify them. The Director of Security stated that Security Officer #3 just deactivated the alarm without checking if a resident exited the facility. The Director of Security stated there are always three Security Officers on duty on each shift. The Director of Security stated they reviewed the video footage, and a timeline was made. The Director of Security stated the Security Officer #3 received in service on elopement prevention prior the incident. During an interview on 04/07/2025 at 2:30 PM the Administrator stated they were notified of the incident on 10/04/2024 at 11:50 AM by the Associate Director of Nursing and the Director of Security. The Administrator stated they were informed that the alarm system did not malfunction, but that the code alert sensor in the elevator had less sensitivity. The Administrator stated that they had to increase the audible decibels and covered the sensors in the elevator to increase the alarm sound. They also stated when a resident wearing a wander guard enters the elevator the alarm will automatically signal to the Life Safety Committee via group text to alert them of the activation of the alarm. This will prevent future occurrence of elopement. The Administrator stated in the East lobby entrance the alarm was activated and sounded, but Security Officer #3 did not go around the perimeter and they did not find out why the system alarmed. Security Officer #3 did not follow the policy protocol and just deactivated the alarm without calling the Director of Security. The Administrator stated to prevent reoccurrence, the Command Center had an After- Action Report/Improvement Plan on 10/04/2024 and completed it on 10/05/2024. 10NYCRR415.12(h)(2)