STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335487	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Johnland Nursing Center Inc	395 Sunken Meadow Road Kings Park, NY 11754

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** Based on observation, interviews and record review during an abbreviated survey intake number 2707253 the facility failed to ensure adequate supervision and timely risk assessment for an elopement for one (1) of three (3) sampled residents (Resident #1). Specifically, Resident #1 verbalized the desire to leave the facility to a provider who reported it to facility staff, the facility failed to follow the elopement prevention policy and assessed for elopement risk or implement supervision. Resident #1 eloped from the facility and was found outside on the facility grounds 30 minutes later. Findings include:Resident #1 was admitted to the facility on [DATE] with diagnoses including stroke, hemiparesis, and urinary tract infection. A Minimum Data Set Brief Interview for Mental Status (BIMS) completed on 12/09/2025 documented a score of 11, indicating moderate cognitive impairment.Facility policy titled Elopement Prevention (dated 2020) required that upon a significant change in condition, each resident be assessed for elopement risk using the Elopement Risk Tool, and that appropriate interventions be implemented as indicated.A Wandering/Elopement Evaluation dated 12/08/2025 documented that Resident #1 was not at risk for elopement at that time.Neuropsychology Note by Psychologist #1 on 01/03/2026 at 02:34PM documented Resident #1 was observed walking unassisted into dayroom with staff members encouraging them to sit. They looked to exit the door unused other than for emergencies. Resident #1 sat, trying to convince staff to allow them to leave. The note further documented Resident #1 baseline personality structure likely included some degree of suspiciousness, but this trait was likely exacerbated by the stroke; it appeared more intense than the reduction in suspiciousness that had been previously noted when compared to initial consultation. The Note documents Resident #1 were also oriented on initial consult; today they stated it was 12/17/2026. Resident #1 expressed feeling less anxious at end of our meeting. Nursing is aware of mental status change and the need for continued observation with additional steps taken as defined by Medical Doctor who is being apprised of resident's condition by Registered Nurse. Will continue to follow throughout rehab stay.There is no documented evidence that an elopement risk reassessment was completed after 1/3/2026 when staff became aware of Resident #1 desire to leave. There is no documented evidence of enhanced supervision or elopement interventions on 1-3-2026.Nursing Progress Note dated 1/3/2026 at 9:04 pm by Licensed Practical Nurse #1 documented Resident alert and verbally responsive with periods of confusion. Medical Doctor was notified at 7:35 PM by the on-call supervisor that the resident was found outside the building at approximately 6 PM, sitting on the curb with no apparent distress. Resident #1 was safely brought back to the unit. Medical Doctor evaluated the situation and advised transfer to the emergency room for further evaluation.Video surveillance was reviewed by state agency and the Administrator on 01/15/2026 at 12:05 PM showed that on 01/03/2026 at approximately 5:17 PM, Resident #1 exited the facility through an exterior door unaccompanied and undetected. At approximately 5:52 PM, staff are observed entering the building with Resident #1.The temperature around the facility on (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335487	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Johnland Nursing Center Inc	395 Sunken Meadow Road Kings Park, NY 11754

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	01/03/2025 as recorded by www.weather.gov documented the high of 30degrees Celsius and low of 20 degrees Celsius.Facility Accident and Investigation dated 01/03/2026 documented Resident #1 left the facility and was found outside approximately 30 minutes later, uninjured. The Certified Nursing Assistant assigned to Resident #1 on the Head Injury Rehabilitation Unit (HIRU) reported that they last observed Resident #1 at approximately 5:00 PM. The report concluded there was no neglect or failure to supervise. Facility five (5) day report submitted to the New York State Department of Health dated 01/06/2026 documented Resident #1 was ambulating independently throughout the elopement, consistent with their baseline functional mobility with residual left?sided hemiparesis. During an interview with Psychologist #1 on 01/15/2026 at 2:25 PM, the psychologist stated that Resident #1's desire to leave was new and different from prior behavior, and that the resident had never previously voiced exit-seeking behavior. They stated the unit nurse was aware of exit seeking behavior and was working to inform the Medical Doctor.Registered Nurse Supervisor was not available for an interview on 1/15/2026.During an interview with the Director of Nursing on 01/15/2026 at 9:15 AM, the Director confirmed that Resident #1 was found outside the facility and has since been discharged to an assisted living facility. During a telephonic interview with Director of Nursing on 02/25/2025 at 10:01 AM they stated Resident #1 left the facility through a door adjacent to the kitchen area. They stated the Registered Nurse Supervisor was responsible to assess Resident #1 for elopement risk when they began voicing a desire to leave but they were responding to a fall at the time. Resident #1 eloped before they could be seen by the Registered Nurse Supervisor. 415.12(h)(1)