

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335522	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Harlem Ctr for Nursing and Rehabilitation, L L C		STREET ADDRESS, CITY, STATE, ZIP CODE 30 West 138th Street New York, NY 10037	

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** Based on observation, record review, and interviews during an abbreviated survey (NY00375711), the facility did not ensure each resident received adequate supervision to prevent an elopement. This was evident for one (1) of four (4) residents (Resident #1), sampled for elopement. Specifically, the facility's video surveillance footage dated 03/19/2025 at 4:04:06 PM showed Resident #1 walked past Security Guard #1, who was sitting at the front desk in the lobby with their head down. Security Guard #1 did not stop Resident #1 from leaving the facility. Resident #1 exited the automatic front doors and left the facility. Staff interviews and the facility's investigative report revealed that the facility was not aware Resident #1 was missing until 7:30 PM. To date, Resident #1 has not been located.</p> <p>This resulted in the potential for serious harm to Resident #1 that was determined to be Immediate Jeopardy Past Noncompliance.</p> <p>The findings are:</p> <p>The facility's Policy and Procedure titled Elopement, dated 02/24/2024, states if an employee observes a resident leaving the premises, he/she should: attempt to prevent the departure in a courteous manner; get help from other staff members in the immediate vicinity, if necessary; instruct another staff member to inform the Charge Nurse or Director of Nursing Services that a resident has left the premises.</p> <p>The facility's Policy and Procedure titled Front Desk and Security, dated 02/28/2024, stated that the purpose was to enhance visitor tracking, ensure compliance with sign-in/sign-out procedures, and to improve security measures to prevent unauthorized resident departures.</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia (a type of schizophrenia characterized by persistent delusions and hallucinations with paranoia) and dementia (a brain condition that affects thinking, memory, and behavior.)</p> <p>The Minimum Data Set (an assessment tool) dated 03/12/2025 documented Resident #1 had a Brief Interview of Mental Status (used to determine attention, orientation, and ability to recall information) score of 12 indicating moderately impaired cognition. Resident #1 ambulated without assistive devices.</p> <p>An Elopement Risk Assessment from 05/23/2023 to 03/06/2025 documented Resident #1 was not identified at risk for elopement; therefore, an elopement care plan was not implemented.</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>The facility's video surveillance footage dated 03/19/2025 showed Resident #1 with a coat on exited the elevator from the unit into the lobby at 4:04.06 PM. Resident #1 walked past Security Guard #1 at the front desk and exited through the automatic front door. Security Guard #1 was observed sitting at the front desk with their head down. Security Guard #1 did not stop Resident #1 from exiting the facility. Security Guard #2 was observed exiting the bathroom at 4:04:21 PM.</p> <p>The facility's Incident Investigative Report dated 03/26/2025 documented on 03/19/2025 at 4:00 PM, Resident #1 left the building. At the time of the report, a full facility-wide search had been initiated and staff were already searching the surrounding neighborhood and Staff searched Resident #1's former apartment building. Hospitals and surrounding shelters were called but the resident was not identified in these places. On 03/19/2025 at 11:00 PM, local law enforcement was called and arrived at the facility at approximately 2:00 AM on 03/20/2025. A review of the video surveillance footage confirmed Resident #1 exited the facility at 4:00 PM on 03/19/2025. The facility concluded that Resident #1 eloped from the facility at 4:00 PM.</p> <p>A nursing progress note dated 03/19/2025 at 10:10 PM by Assistant Director of Nursing #1 documented that on 03/19/2025 at 9:30 PM, Registered Nurse Supervisor #1 contacted them to report Resident #1 had eloped from the facility. The nursing staff did not notice Resident #1's absence until 7:30 PM. Registered Nurse Supervisor #1 was alerted at 7:30 PM. A Code Grey (elopement code) was activated facility-wide, a neighborhood search was conducted, and the Administrator and Director of Nursing were informed.</p> <p>During an interview on 03/31/2025 at 4:25 PM, Certified Nursing Assistant #1 stated they worked on the evening shift of 03/19/2025 from 3:45 PM - 11:45 PM. Certified Nursing Assistant #1 stated they observed Resident #1 at the unit elevator at 4:00 PM; Resident #1 stated they were going downstairs to get snacks from the vending machine. Certified Nursing Assistant #1 stated they did not stop Resident #1 from going downstairs because the Resident was allowed to do this. Certified Nursing Assistant #1 stated Resident #1 had never verbalized wanting to leave the facility and was never observed packing their belongings. Certified Nursing Assistant #1 stated they took their dinner break from 6:30 PM - 7:30 PM after serving dinner to the residents, and they returned to the unit at 7:30 PM. Certified Nursing Assistant #1 stated when they returned from their break and made rounds, Resident #1's dinner tray was in their room, untouched. Certified Nursing Assistant #1 stated they immediately informed Licensed Practical Nurse #1 and began to search for Resident #1 but was unable to locate them.</p> <p>During an interview on 03/31/2025 at 4:19 PM, Licensed Practical Nurse #1 stated they worked on the evening shift of 03/19/2025 from 3:30 PM - 11:45 PM. Licensed Practical Nurse #1 stated they performed rounds on the unit at 3:30 PM and Resident #1 was observed sitting in their room. Licensed Practical Nurse #1 stated they were notified by Certified Nursing Assistant #1 at approximately 7:30 PM that Resident #1 was not in their room. Licensed Practical Nurse #1 stated it was normal for Resident #1 to leave the unit unsupervised to go to the vending machine prior to dinner, which is served between 6:00 PM and 6:30 PM. Licensed Practical Nurse #1 stated Resident #1 usually returned to the unit after getting their snacks and that Resident #1 had no known exit-seeking behavior. Licensed Practical Nurse #1 stated after they searched the lobby and unit, they notified Registered Nursing Supervisor #1 at approximately 7:30 PM and a Code Grey was called at 8:00 PM.</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 03/31/2025 at 1:31 PM Registered Nursing Supervisor #1 stated they were informed by Licensed Practical Nurse #1 at approximately 7:30 PM - 8:00 PM on 03/19/2025 that they were unable find Resident #1. Registered Nursing Supervisor #1 stated they called a Code Grey at approximately 8:00 PM and the search for Resident #1 was unsuccessful. Registered Nursing Supervisor #1 stated they called the Director of Nursing and the Administrator and notified them Resident #1 was missing. Registered Nursing Supervisor #1 stated local law enforcement was called on 03/19/2025 at 11:00 PM and they arrived at the facility on 03/20/2025 at 2:00 AM. Registered Nursing Supervisor #1 stated Resident #1 was not at risk for elopement and had never verbalized or attempted to leave the facility. Registered Nursing Supervisor #1 stated all residents are on 30-minute visual monitoring for safety, that was not documented. They only document monitoring for Residents who are at risk for elopement.</p> <p>During an interview on 04/01/2024 at 1:53 PM, Security Guard #1 stated 03/19/2025 was their first day on the job and they were receiving training. Security Guard #1 stated they were left alone at the front desk by Security Guard #2, who was training them. Security Guard #1 stated they did not know Resident #1, and they did not know the people leaving the facility. Security Guard #1 stated they became aware a week later that a resident walked out of the facility while they were sitting at the front desk.</p> <p>During an interview on 04/02/2025 at 4:39 PM, Security Guard #2 stated they worked on the morning shift on 03/19/2025 from 9:00 AM - 5:00 PM. Security Guard #2 stated they were training Security Guard #1 but left them and went to the bathroom for approximately 2-3 minutes. Security Guard #2 stated when they returned to the front desk, neither Security Guard #1 nor any other staff members notified them that Resident #1 had left the building. Security Guard #2 stated they became aware of the elopement two days later when they returned to work. Security Guard #2 stated Resident #1 usually came down to the vending machine in the lobby during the evening to get snacks. Security Guard #2 also stated Resident #1 normally sat in the lobby for a while before returning to their unit. Security Guard #2 stated Resident #1 never attempted to leave nor verbalized wanting to leave the facility.</p> <p>During an interview on 03/31/2025 at 1:17 PM, the Director of Nursing stated they were notified that Resident #1 was missing on 03/19/2025 at 9:00 PM by Registered Nursing Supervisor #1 The Director of Nursing stated they instructed Registered Nursing Supervisor #1 to search the entire building and surrounding areas. The Director of Nursing stated a Code Grey was called at 8:00 PM and staff members continued searching for Resident #1. The Director of Nursing stated Resident #1 had been living in the facility for nearly two years and had never exhibited any exit-seeking behavior, and never attempted to nor verbalized wanting to leave the facility. The Director of Nursing stated they called the surrounding hospitals and shelters, and they went to Resident #1's previous home address but was unsuccessful in locating Resident #1.</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 03/31/2025 at 11:03 AM, the Administrator stated they were made aware of the elopement at 9:30 PM on 03/19/2025. The Administrator stated there were two security guards at the front desk; Security Guard #1 was being trained by Security Guard #2. The Administrator stated Resident #1 walked past Security Guard #1 shortly after Security Guard #2 got up from the front desk to go to the restroom. The Administrator stated it was Resident #1's routine to purchase snacks from the vending machine in the lobby and then return to their unit. The Administrator stated all visitors entering the building must sign in; however, they were not required to sign out. The Administrator stated they reviewed the video surveillance footage, which showed Resident #1 left the facility at 4:00 PM without anyone knowing. The Administrator stated the police were still looking for Resident #1 and would keep them updated. The Administrator stated they provided staff members with elopement in-service and elopement drills. The Administrator stated they have also implemented new measures to prevent resident elopement.</p> <p>During an interview on 04/01/2025 at 1:42 PM, the Medical Doctor stated they have been providing care to Resident #1 for over a year, and during their interactions Resident #1 had never verbalized wanting to leave the facility. The Medical Doctor stated they were informed by the facility that Resident #1 was missing on 03/19/2025.</p> <p>The Immediate Jeopardy was determined to have begun on 03/19/2025. The Administrator was informed of the Immediate Jeopardy and provided with the Past Noncompliance Immediate Jeopardy Template on 04/01/2025 at 4:32 PM.</p> <p>Based on the following corrective actions taken, there was sufficient evidence the facility corrected the noncompliance and was in substantial compliance for this specific regulatory requirement prior to the start (03/31/2025) of this survey. As such, a Plan of Correction is not required for this citation.</p> <p>The facility took immediate corrective actions and was found to be in substantial compliance on 03/24/2025 prior to surveyor entrance on 03/31/2025 at 9:00 AM.</p> <p>Facility initiated an investigation 03/19/2024 at 9:30 PM.</p> <p>03/19/2025 at 11:00 PM - Reported to Department of Health.</p> <p>03/19/2025 at 11:00 PM - 911/police notified and responded on 03/20/2025 at 2:00 AM.</p> <p>03/20/2025 - All staff in-serviced on the elopement policy. Topics: Hand-Off-Report - Rounding with Incoming Staff, Elopement, Effective Rounding, Timely Reporting Significant Elopement -Significant issues.</p> <p>03/20/2025 - An Audit Tool initiated to assess Residents who may be at risk for elopement. Audit is ongoing.</p> <p>03/20/2025 - Unit staff were given verbal counseling regarding proper reporting, effective rounding.</p> <p>03/20/2025 - An Elopement Risk Tool developed. Three Residents who wander on the unit were re-assessed for elopement risk.</p> <p>(continued on next page)</p>		

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