STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335541	A. Building B. Wing	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masonic Care Community of New York	2150 Bleecker Street Utica, NY 13501

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Based on observations, record review, and interviews conducted during the abbreviated (iQIES incident #2607732) survey, the facility failed to ensure residents received adequate supervision to prevent accidents for two (2) of five (5,) residents (Residents #1 and #3) reviewed for accidents. Specifically, Resident #1 was at risk for elopement and exited the facility undetected on 09/03/2025 and 10/25/2025; and Resident #3 left the facility grounds on 07/25/2025, undetected, on their motorized scooter and was found two (2) hours later at a fast-food restaurant approximately four (4) miles away. This resulted in Immediate Jeopardy and Substandard Quality of Care to Resident #1 and #3 and placed all 59 residents with exit-seeking behaviors at risk for serious harm, serious injury, serious impairment, or death. The facility policy Elopement Risk Screen, revised 07/2011, documented staff would monitor a resident's whereabouts to ensure they remained within the facility. In the event of an elopement or elopement attempt, staff notified the Nurse Manager or supervisor. The policy did not include procedures for disarming the sounding alarm.The facility policy Missing Resident: Code Yellow, revised 12/2015, documented when a resident was missing from the unit, the unit staff members were to immediately notify the supervisor, alert the receptionist, and a formal announcement (overhead) was made. All unit staff initiated a search of all areas on the unit and report the results to the receptionist. Ancillary staff and one (1) staff member from each unit conducted a search of other assigned areas within the facility. 1) Resident #1 had diagnoses including Alzheimer's dementia, repeated falls, and difficulty walking. The 06/19/2025 Minimum Data Set (a resident assessment tool) documented the resident had severely impaired cognition, did not exhibit wandering behavior, required supervision for walking, received daily antipsychotic and antidepressant medications, and used a wander detection device.The 09/30/2024 admission Elopement Screen documented the resident's scored a 16 out of 28. A score greater than 10 indicated an elopement risk. The Comprehensive Care Plan initiated 10/12/2024 documented the resident was at elopement risk as per Elopement Risk Data Collection. Interventions included: complete elopement risk screen; gather history of wandering/elopement attempts; observe and identify behavior/patterns of mobility such as pacing, searching, etc.; wander detection device to right ankle, check three (3) times a day on day, evening, and night shifts. On 02/06/2025 at 11:00 AM, the resident was found on the second step on the stairwell after the alarm sounded. A stop sign was added to the stairwell door as well as a red barrier gate, and the wander alert device range was extended. On 04/10/2025, the resident surpassed the wander alert alarm and was found at the bottom of the stairwell. On 06/01/2025, the resident's wander alert device was alarming in the stairwell. A certified nurse aide found the resident at the bottom of the stairwell trying to push on the door to go into the hallway near the lobby. Approaches included continue interventions. On 06/08/2025, the resident was found on the first-floor landing in the stairwell with their wander alert device alarming. Approaches included continue interventions. On 06/28/2025, the stairwell was alarming, and the resident was not seen in the stairwell. The resident was found in the front lobby. Interventions included continue with wander alert device, stop signs, and consider room move. The 09/2025 Medication Administration Record documented 15-minute checks for frequent falls with a start date of 01/03/2025. The 15-minutes checks were documented as completed on 09/03/2025 during the 3:00 PM-11:00 PM shift by Licensed Practical Nurse #4. There was no documented evidence of actual times when 15-minute checks were completed. The 09/03/2025 at 4:50 PM progress note by Licensed Practical Nurse #7, documented the resident was wandering on and off the unit constantly, was redirected with short term effect, 15-minute checks were done, and staff were to continue to monitor the resident.The 09/03/2025 incident report completed by Registered Nurse Supervisor #3, documented Resident #1 eloped on the evening shift and was found outside. Registered Nurse Supervisor #3 was called to the resident's unit at 7:33 PM, as the resident had been found outside by security. The resident went down the back stairwell and out the exit door making their way to the grounds fence near a main road. Registered Nurse Supervisor #3 and Licensed Practical Nurse #4 went outside to get the resident. The resident was wearing a wander detection device, and the alarms sounded. The investigation determined the apparent timeline was the resident pushed the unit stairwell door open at 6:55 PM, exited an outside stairwell door sometime between 6:55 PM and 7:05 PM, a visitor went to the front desk at 7:13 PM and stated there was a [person] standing against the fence near the road. Security was called and found the resident on the corner of the facility property. Unit staff were notified to come get the resident, while security monitored the resident. Staff arrived at 7:22 PM with a wheelchair and brought Resident #1 back into the facility. The resident was assessed by Registered