| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335571 | A. Building<br>B. Wing | 12/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Rockaway Care Center | 353 Beach 48th Street<br>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) |
|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews during an abbreviated survey (459982), the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents. This was evident in one (1) of 12 residents (Resident #1) sampled for elopement. Specifically, Resident #1 left the building on 02/17/2025 at 4:03 PM after being buzzed out the exit door in the lobby by Security Guard #1. Facility staff did not become aware that Resident #1 was not in the building until 5:35 PM. On 02/18/2025 at 1:20 AM, the hospital notified Nursing Supervisor #2 that Resident #1 was in the hospital. A review of the hospital Discharge summary dated [DATE] revealed Resident #1 was admitted to the hospital with diagnoses of encephalopathy (any disease or disorder that affects brain function or structure) secondary to hypothermia (core body temperature drops below 95 degrees Fahrenheit), and acute kidney injury. This resulted in actual harm to Resident #1 that was not Immediate JeopardyThe findings include:A review of the Elopement Prevention/Wandering Behavior Management policy dated 06/09/2022 documented it is the policy of the facility to utilize all possible measures to maintain the safety and well-being of all residents. To have system and tools in place to do all that is reasonable to identify and prevent unsafe wandering and or elopement and to act quickly prudently should either occur. Elopement occurs when a resident leaves the premises or a safe area without authorization and or any necessary supervision to do so.A review of the Front Desk/Security Monitoring policy and procedure dated 01/27/2025 documented to ensure the safety and security of all residents, staff, visitors, and property within the facility by establishing clear procedures for front desk security monitoring and access control. It is the policy of the facility that the front desk serves as the primary security checkpoint. All individuals entering or exiting the facility must be screened appropriately, and all activities at the front entrance must be monitored consistently and in accordance with safety protocols. Front Desk Staff shall monitor all persons entering or exiting the facility. Ensure all visitors log in through the electronic monitoring system; Ensure visitors signs in/out; always wear a visitor badge and always maintain a visible and alert present at the front desk. Resident #1 was admitted to the facility with diagnoses of dementia (a severe decline in mental abilities), psychotic disorder (a serious mental illness where a person loses touch with reality) with delusion (a delusion is a fixed, false belief firmly held despite evidence to the contrary, often involving misinterpretations of reality) and anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome.) The Minimum Data Set (a resident assessment tool) dated 11/24/2024 documented Resident #1 ambulated independently. The Elopement Risk Assessment was last updated on 11/13/2024 and documented Resident #1 was at risk for elopement and refused to wear a wander guard.A review of an Elopement Care Plan updated on 11/13/2024, documented Resident #1 walked out of the building on 11/12/2024. Security followed Resident #1, and the police were called and responded. Resident #1 returned to the facility, and 30-minute visual checks continued. A Plan of Care note dated 11/13/2024 documented that on 11/12/2024 at 6:45 PM, Security Guard #2 reported that Resident #1 walked out the building as staff were entering the building. Security Guard #2 followed Resident #1 out of the building. Police were called and Resident #1 was returned to the building. Every 30-minute visual checks continued. A physician's order dated 01/27/2025 documented Resident #1 was high risk for elopement and 30-minute visual checks for safety. A review of the Resident Observation/Rounding Report document dated from 02/10/2025 through 02/17/2025 showed Resident #1 was being monitored every two hours as indicated by staff initials. The last entry for 02/17/2025 showed Resident #1 was last seen at 4:00 PM talking with a family member. The Resident Nursing Instructions record dated 02/2025 documented Resident #1 was on behavior monitoring for elopement and wandering on the unit.A review of the 3:00 PM - 11:00 PM Visual Checks for Residents Unit dated 02/17/2025 revealed Resident #1 was on 30-minute monitoring. Documentation on 02/17/2025 showed staff last signed for Resident #1 at 4:00 PM. Review of a nursing note by Licensed Practical Nurse #1 dated 02/17/2025 at 11:36 PM, documented during rounds they observed Resident #1 sitting quietly in the hallway at 3:35 PM. All residents were accounted for and everyone was okay. At approximately 5:35 PM Certified Nursing Assistant #1 informed them that Resident #1 was not in their room. Licensed Practical Nurse #1 immediately instructed all staff to check for Resident #1. Security Guard #1 was called and a check was done in the main Dining Room and Resident #1 was not found. Registered Nurse Supervisor #1 was notified at 5:40 PM. Code Pink (an elopement code) was activated and 911 was called. Review of a nursing note by Registered Nurse |