STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335653	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menorah Home & Hospital for Aged & Infirm	1516 Oriental Blvd Brooklyn, NY 11235

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48876 Based on record review and interviews conducted during the Recertification and Complaint Survey (NY00343354) from 10/8/2024 to 10/16/2024, the facility did not ensure that all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made, to the State Survey Agency in accordance with State law through established procedures. This was evident for 1 (Resident #357) of 4 residents investigated for Abuse out of an investigative sample of 38 total residents. Specifically, the facility received a report that Resident #357 was allegedly missing cash totaling approximately $900 and did not report to the New York State Department of Health in a timely manner. The findings are: The facility policy titled Abuse Prohibition dated 10/24/2022, documented that the facility shall not use or permit verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion of residents/patients, misappropriation of resident property, exploitation or other mistreatment or neglect. Section 1150B establishes two-time limits for the reporting of reasonable suspicion of a crime. One of the time frames is Immediately: Means as soon as possible, in the absence of shorter state time frame requirement, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or results in serious bodily injury. All staff members have an obligation to report any reasonable suspicion of a crime to the State Survey Agency (New York State Department of Health's Nursing Home Complaint Hotline). The facility shall ensure that alleged violations involving mistreatment, neglect, misappropriation of resident property, exploitation, or abuse, including significant injuries of unknown source, are reported immediately to the Administrator of the facility or his/her designee. When required by law or regulation, the facility shall ensure timely notification to the Department of Health. Resident #357 was admitted to the facility with diagnoses that included Cerebral Infarction and Depression. The Minimum Data Set assessment dated [DATE], documented that Resident #357 had intact cognition. (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: 335653	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/09/2024 at 12:38 PM, an interview was conducted with Resident #357 who stated, that after the aide cleaned them up, their wallet and envelope were missing. Resident #357 also stated that the items were near a pillow in their bed and after a search the wallet was recovered but the envelope containing approximately $900 was missing. The facility complaint investigation, initiated 05/24/2024 and submitted 05/31/2024, documented Resident #357 reported an allegation of missing between $700-$900 on 05/24/2024 at 04:00 hours after receiving care from the Certified Nursing Assistant who allegedly removed an envelope containing cash from the bed pillow and never returned it. The police were notified on 05/24/2024. The New York State Department of Health Aspen Complaint Tracking System Intake Information documented that the allegation was reported on 05/25/2024 at 00:36. There was no documented evidence that the facility reported Resident #357's allegation of misappropriation of property on 05/24/2024 to the New York State Department of Health within 2 hours. On 10/15/2024 at 03:13 PM, an interview was conducted with the Director of Nursing who stated that they received a telephone call at approximately 5 AM or 6 AM on 05/24/2024, reporting that Resident #357 was missing a wallet and an envelope with $700-$900 in cash. The Director of Nursing also stated that they reported the incident to the New York State within 24 hours. The Director of Nursing further stated that they believed the 2 two-hour reporting requirement is only for serious bodily injury and most other reporting is a 24-hour reporting requirement. On 10/16/2024 at 10:35 AM, an interview was conducted with the facility Administrator who stated, on abuse reporting as is for misappropriation of property, this report was not submitted within 2hrs. The Administrator stated they are aware, and the staff has updated the policy to reflect reporting no later than 2 hours after an allegation of abuse. 10 NYCRR 415.4(b)(2)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41709 Based on observation, interviews, and record reviews conducted during the Recertification and Complaint (NY00317447) survey from 10/08/2024 to 10/16/2024, the facility did not ensure resident's person-centered, Comprehensive Care Plans were reviewed and revised with each assessment and as needed to reflect the resident's changing needs. This was evident for 1 (Resident #389) of 5 residents reviewed for Unnecessary Medication, and 1 (Resident 84) of 4 residents reviewed for Abuse out of an investigative sample of 38 residents. Specifically, the Psychoactive Drug Use Comprehensive care plan for Resident #389 was not reviewed or revised after each assessment, and Risk for Victimization Comprehensive care plan for Resident # 84 was not review or revised after annual or quarterly assessments. The findings are: The facility policy titled Care Plan revised 08/06/2024 documented that the care plan is reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly assessments. The policy further documented that the care plan should be reviewed and revised Quarterly, Annually, at a Significant change and medical status changes, with changes to the care plan as needed. 1. Resident #389 was admitted to the facility with diagnoses which included Non-Alzheimer's Dementia, Vascular Dementia with Psychotic features, and Depression. The Annual Minimum Data Set, dated dated dated [DATE] and the Quarterly Minimum Data Set, dated dated dated [DATE] documented that the resident had short and long-term memory impairment, no memory recall and was severely impaired-never/rarely made decisions. The Physician orders reviewed 09/30/2024 documented orders for Rexulti 1 mg tablet by oral route once daily for Vascular Dementia with Psychotic disturbances, Trazodone 50 mg tablet by oral route every night for Depression, Lexapro Escitalopram 10 mg tablet by oral route once daily for Depression, and Melatonin 3 mg tablet by oral route once daily at bedtime for Insomnia. The Comprehensive Care Plan titled Psychoactive Drug Use Etiology: Use of any medication that affects mood, function, behavior, or cognition as evidenced by: Psychoactive drug use dated was effective 01/14/2024 and last evaluation note was completed on 04/14/2024. Goal was maximizing functional potential and well-being while minimizing use of medication and side effects, all interventions implemented on 01/18/2024 included encourage verbalization of feelings, monitor for changes in behavior or mood, observe for any signs of decline in functional or cognitive status, psychiatry consultation. The Comprehensive Care Plan for Psychoactive Drug Use was last reviewed on 4/14/2024. There was no documented evidence that Resident # 389 Psychoactive Drug Use care plan had been reviewed and revised by the interdisciplinary team after the quarterly review assessments were completed on 09/19/2024 and 06/26/2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/24 at 11:22 AM, an interview was completed with Registered Nurse #2, who was the Nursing supervisor for the Unit. Registered Nurse #2 reviewed Resident #389's medical record and stated that the care plan was not updated last quarter. Registered Nurse #2 also stated that the supervisors and Registered Nurses are all responsible for updating the care plans. Registered Nurse #2 also stated care plans are updated quarterly, annually, episodic due to behaviors and as needed. Registered Nurse #2 further stated that the night shift usually updates the Psychotropic care plans, and they are not sure why Resident #389's care plan was not updated. Registered Nurse #2 further stated that at times the updating of the care plan is missed although the care plan meeting was completed. Registered Nurse #2 gave no reason why the care plan was not updated. On 10/16/24 at 11:16 AM, an interview was completed with the Director of Nursing who stated that care plans are updated quarterly, annually, and as needed. The Director of Nursing also stated that the Registered Nurses on the units are responsible for initiating and updating all care plans, and that night shift is not the only shift responsible for updating the care plans, but all nurses on every shift are responsible for updating the care plans. The Director of Nursing further stated that they monitor that the supervisors and nurses are reviewing care plans by doing random audits on the units and gave no reason why this care plan for Resident #389 was not reviewed or revised timely. 44843 2. Resident # 84 (NY00317447) was admitted to the facility with diagnoses that included Alzheimer's Disease and Closed fracture of unspecified part of left clavicle. The Annual Minimum Data Set assessment dated [DATE] documented Resident #84 had moderately impaired cognition, had no behavior symptoms, and was always incontinent in of bladder. The Annual Minimum Data Set also documented that Resident #84 required supervision to walk in room and had not fallen since admission. The Comprehensive Care Plan related to Resident is at Risk for Victimization was initiated 3/23/2023 and was reviewed and updated on 06/16/2023 and 05/30/2024. A Nursing note dated 5/30/2023 documented that a Certified Nursing Assistant noticed Resident #84 had discoloration to the left shoulder when providing care to Resident #84. The note also documented that Resident #84 had pain at the left shoulder and left shoulder movement was limited. The note also documented Resident #84 stated they fell at night on 05/29/2023 when going to bathroom by themselves and had pain in the left shoulder. A Nursing note dated 5/30/2023 documented that Resident #84 was transferred to the hospital to rule out a left humerus fracture. The Hospital After Visit Summary dated 5/30/2023 documented that Resident #84 had a closed nondisplaced fracture of left clavicle. Quarterly Minimum Data Set assessments were completed on 09/06/2023, 11/27/2023, 02/21/2024, and 8/12/2024, and an Annual Minimum Data Set assessment was completed on 05/15/2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence that the Comprehensive Care Plan titled At risk for Victimization was reviewed or revised after multiple Quarterly and Annual Minimum Data Set assessments had been completed. On 10/11/2024 at 10:13 AM, Registered Nurse #2 was interviewed and stated the Registered Nurses on the floor are responsible for reviewing and updating residents' care plans at least every 3 months and as needed. Registered Nurse #2 also stated that the electronic medical record system gave them alert when the care plans were due for review, and the Registered Nurse reviewing the care plans should either update the care plan, or document to continue current care plan if no change was required as evidence that the care plan was reviewed. After review of Resident #64's medical record, Registered Nurse #2 stated that there was no evidence that the care plan was reviewed between 6/17/2023 and 5/29/2024, and after 5/30/2024. Registered Nurse #2 further stated that they were not able to explain why the care plan was not reviewed and updated at least every three months. On 10/11/2024 at 10:39 AM, the Director of Nursing was interviewed and stated the registered nurses on the unit were responsible to review and update care plans at least every 3 months and as needed. The Director of Nursing also stated that the Registered Nurse is to document to continue the care plan if no change was needed. The Director of Nursing further stated that it was an error that the care plan was not updated at least every 3 months and after the Minimum Data Set assessments had been completed. The Director of Nursing also stated that the Registered Nurses were professional, and they did not monitor to see if the Registered Nurses reviewed and updated the care plans. 10 NYCRR 415.11(c)(2)(i-iii)

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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** 44864 Based on interviews and record review conducted during a Recertification and Complaint survey (NY00328780) from 10/08/2024 to 10/16/2024, the facility failed to ensure each resident received adequate supervision to prevent elopement. This was evident for 1 (Resident #369) of 3 residents investigated for Accidents out of an investigative sample of 38 residents. Specifically, on 11/23/2023, Resident #369 who was not identified as a high risk for elopement, was able to exit the front doors of the facility and walk down to the guard booth where Resident#369 was then redirected and taken back into the facility. The findings are: The facility's Elopement Policy titled Elopement Prevention and Management, created 8/11/2015 and last reviewed 11/27/2023, documented that the facility maintains measures to ensure safety and well-being of residents within the confines of the facility. The policy also documented that elopement occurs when a resident successfully leaves the nursing facility undetected and unsupervised and enters harm's way. The New York State Department of Health Aspen Complaint Tracking System intake documented that on 11/24/2023, the Security Coordinator reported that on 11/23/2023, at approximately 3:47 p.m., Resident #369 left the facility and returned a few minutes later. Resident #369 was observed by a Security Officer in the booth to be close to the guard booth, and then another Security Officer followed the resident back to the front entrance of the facility. Resident #369 was admitted to the facility with diagnoses that include Alzheimer's Disease, Non-Alzheimer's Dementia, and Depression. The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #369's cognition as severely impaired-never/rarely made decisions, wanders with behavior of this type occurring 1 to 3 days, ambulates with walker, and uses a wheelchair. The Quarterly Minimum Data Set assessment also documented that Resident #369 has no wander or elopement alarm. The Elopement Risk assessment dated [DATE] documented that Resident #369 is independently mobile, with or without an assistive device, has a primary diagnosis of Alzheimer's Disease or Dementia, and has an active Mental Illness. The Elopement Risk Assessment also documented that Resident #369 was not an elopement risk. A Nursing note dated 11/24/2023 documented that Resident #369's family member was notified that Resident #369 went out of the lobby on 11/23/2023 around 3:40pm. A Nursing note dated 11/24/2023 documented that Resident #369 was alert and responsive to all stimuli but had occasional confusion. Resident #369 has left ankle wander-Guard in place due to elopement risk. Resident #369 made no attempts to leave unit on shift and was observed ambulating on the unit with a rolling walker and supervision. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician's note dated 11/24/2023 documented Resident #369 was awake, alert, verbally responsive with periods of confusion denied pain, has no visible signs of injury, and no changes in range of motion. The Physician's note also documented Resident #369 was stable with no injury and is able ambulate on unit with a rolling walker and supervision. The facility's investigation report dated 11/30/2023, documented the event as an elopement and that on 11/23/2023, Resident #369 went outside the lobby to take fresh air. The incident report further stated that on 11/23/2023, Resident #369 attended a Thanksgiving event in the facility auditorium and when the activity ended, Resident #369 was sitting on a chair waiting to be transported. Resident #369 was not observed leaving the event. The incident report further stated that it appears that Resident #369 stepped outside of the auditorium into the lobby and that the security officers at the entrance to the facility, were distracted and did not notice the resident walking outside the facility. The resident was identified by the security staff outside the facility looking for an entrance to come back into the facility. On 10/16/2024 at 01:19 PM, Certified Nursing Assistant #2 was interviewed and stated that they had been assigned to Resident #369 on 11/23/2023, and on that day, they had just started their shift 2 PM-10 PM, when the recreation staff came and took Resident #369 off the unit for recreation. Certified Nursing Assistant #2 also stated that Resident #369 was alert and oriented and needed supervision with their activities of daily living. Certified Nursing Assistant #2 further stated that they were not aware that Resident #369 went outside until later that day. On 10/15/2024 at 10:19 AM, Recreation Leader #1 was interviewed and stated that on 11/23/2023, they had signed out Resident #369 off the unit, and brought them to the auditorium on the 1st floor, for the Thanksgiving Day program. Recreation Leader #1 also stated that Resident #369 was at the program, sitting at the back of the Auditorium, and it was when they came back from transporting other residents back to their units at the end of the program, that they were notified that the Resident#369 went outside and was brought back in. Recreation Leader #1 further stated that the recreation staff usually transport the residents that are an elopement risk back to their rooms first, but at the time of the incident, Resident#369 was not an elopement risk. of residents and that they never exhibited any exit seeking behaviors prior to that incident. On 10/15/2024 at 11:20 AM, Recreation Leader #2 was interviewed and stated that they worked on 11/23/2023, and was made aware on the next day, 11/24/23, that Resident #369 went out the building. Recreation Leader #2 said that they recalled Resident #369 was sitting by the door of the auditorium during the Thanksgiving Day program, and that Resident #369 always came down for programs but never displayed any exit seeking behaviors. Recreation Leader #2 said that when the residents who are an elopement risks come off the units for programs on the 1st floor, they are placed in the middle of the room, and are taken back to their units first. Recreation Leader #2 stated that since Resident #369 was not an elopement risk, they were sitting at the end of the room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/2024 at 10:26 AM Social Worker #1 was interviewed and stated that they were the Social Worker for the Resident #369 at the time of the elopement, 11/23/2023. The Social Worker stated that an initial elopement risk is done by the nurse on the unit when residents are initially admitted . The Social Worker stated that upon interview with Resident #369 when the incident occurred on 11/23/2023, Resident #369 said that they were going for a walk and that they (Resident #369), was not trying to leave the facility. The Social Worker stated that the interdisciplinary team then had a meeting it was decided that Resident #369 would be placed on a long-term floor, the Dementia unit, since Resident #369 had Dementia and had been more confused recently. On 10/15/2024 at 04:07 PM, Security Officer #1 was interviewed and stated that they were stationed at the front desk on 11/23/2023. It was a shift change, when they saw Resident #369 coming back into the front door, as Security Officer #2 approached Resident #369. Security Officer #1 stated that when the Security Coordinator who worked the day shift 8 AM-4 PM shift, returned to the desk, Security Coordinator said that they would report the elopement incident to the facility Administrator. Security Officer #1 also stated that there is a wander guard list in a binder that has residents' pictures on it, located at the front desk. On 10/15/2024 at 03:42 PM, Security Officer #2 was interviewed and stated that on 11/23/2023, at the time the elopement incident occurred, they were looking in the opposite direction, writing up a day pass. and was facing the opposite direction. Security Officer #2 also stated that when they raised up their head, they saw the Resident #369 coming back inside, and went to the door to Resident #369. Security Officer #2 further stated that at the same time, the Security Coordinator came back to the desk, and they notified the Security Coordinator. Security Officer #2 stated that they do not think that Resident #369 had a wander guard on because the alarm would have been triggered as the resident walked through the door, and that at the security desk, they have a list of residents that are elopement risk and have wander guards. On 10/15/2024 at 09:45 AM, the Security Supervisor was interviewed and stated that on the day that the elopement occurred on 11/23/2023, they did not work. The Security Supervisor stated that as the security supervisor, they are responsible to make sure that the all the processes are followed, as it pertains to the security. The Security Supervisor stated that on 11/24/2023, the Security Coordinator told them that the elopement occurred the day before, 11/23/2023, so the Security Supervisor told the Security Coordinator that they needed to report it immediately. The Security Supervisor also stated that they were made aware that Resident #369 went through the main entrance, and that they did not have a wander guard at the time. The Security Supervisor also stated that if Resident #369 did have a wander guard on, the alert would have been sounded and the resident would have shown up on the camera. On 11/23/2023 when the elopement occurred, there were 2 security officers and the Security Coordinator on the 8 AM-4 PM shift. At the time the incident occurred, the Security Coordinator had stepped away from the desk, so there were only 2 Security Officers at the desk, one was occupied signing in a resident, and the other security was probably signing in another visitor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/2024 at 10:37 AM, the Administrator was interviewed and stated that on Friday, 11/24/2023, they were made aware that Resident #369 went out the front door, by the Security Coordinator who worked on 11/23/2023, on the 8 AM -4 PM shift. The Administrator also stated that they should have been notified immediately when the incident occurred on 11/23/2023 and that once they were notified, they started an investigation, notified the family, and had the Resident #369 seen by the physician. The Administrator stated that the recreation leader had had brought Resident #369 to the auditorium for the Thanksgiving program on 11/23/2023 and that Resident #369 was sitting closer to the door so none of the recreation staff saw Resident # 369 leave the auditorium. The Administrator also stated that on the day that the elopement occurred, one of the security guards did not show did not show up for that shift, and the other security guard at the front desk was not as focused as they should have been when the Resident #369 went outside. That security guard and the Security Coordinator who failed to report the elopement timely, are no longer employed by the facility. The Administrator also stated that they reviewed the cameras footage to see what really transpired and started doing in-services immediately on Elopement with all the departments, and that the facility started to ensure that all departments had a wander guard list with residents who were at risk for elopement, including the guard at the booth at the facility's parking lot entrance. The Administrator also stated that the recreation staff had the list of residents who were elopement risks and that the nurses on the units were notified of residents who were elopement risks who leave the units, prior to the residents leaving the units. When residents who were elopement risks attend the programs in the auditorium, they are now placed at the center of the room and transported back to their units first. The Administrator also stated that they did a facility wide evaluation on all residents to ensure that all at risk residents are identified. All corrective actions and interventions were implemented by 12/13/2023. On 10/16/2024 at 12:55 PM, the Director of Nursing was interviewed and stated that they were first made aware of Resident #369 going through the front entrance on 11/24/2023. The Director of Nursing also stated that they immediately started the investigation, interviewed Resident #369, and started in-services on Elopement. The Director of Nursing further stated that the physician evaluated Resident #369 who had no injuries. The Director of Nursing stated that Resident #369 had an initial assessment for Elopement on 08/04/2023 and one on 11/4/2023, but was not deemed an Elopement risk, however after an assessment was done on 11/24/2023, they determined that Resident #369 was an Elopement Risk and was given a wander guard. The Director of Nursing also stated that they initially checked all the residents with a Dementia diagnosis and who were ambulatory and did a facility wide evaluation for residents at risk for elopement. The Director of Nursing also stated that they reviewed the policy and procedures on Elopement, did an assessment every week for 4 weeks, then quarterly for elopement risks. The facility implemented corrective actions and was found to be in substantial compliance on 12/13/2023 prior to the start of the Recertification Survey on 10/08/2024. Resident #369 was redirected back to the front entrance and walked back into the facility unharmed on 11/23/2023. The Comprehensive Care plan for Elopement for Resident #163 was implemented on 11/24/2023. The policy and procedure on Elopement Prevention and Management was reviewed 11/27/2023, and no changes were made to the policy? (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An ad hoc Quality Assurance Performance Improvement meeting on Elopement Review and Planning was held on 11/27/2023 with the Administrator, Assistant Administrator, the Director of Nursing, Security Supervisor and Director of Social Work. Details included the in-service on Elopement for all facility staff in progress, in service security specific for security staff in progress, and replacement staff for security for further discussion. Security to send current wander guard list to all department heads for review with the updated list to be sent weekly to all departments. Recreation to review and post in the office so recreation staff are aware when residents are off unit. Managers must review the plan of care for all residents identified as wanderers and to identify any other residents that may be affected. Residents that have a diagnosis of Dementia in conjunction with ambulatory status will be reviewed. The recommendation for system improvement documented that Resident #369 was reassessed for elopement risk, and that a wander guard was applied. The corrective action included that Resident #369's chart was reviewed, family notified, the Security Coordinator was removed from schedule and terminated for the delay in reporting the elopement wandering event to Administration and appropriate staff. The relieving Security Coordinator was counselled and reeducated since they stated that they believed the other Security Coordinator reported the incident. The Security Guard was relieved from duty pending investigation and was no longer employed at the facility. The facility's Plan of Prevention was reviewed and was acceptable. 1. On 11/24/2023 the Resident #369's risk of wandering and elopement was reassessed. Wander guard was applied, Resident #369's photo was added to the Elopement risk binder. 2. Medical evaluation post incident. 3. Family was notified. 4. Resident #369's chart was reviewed and revised the plan of care for Elopement which was implemented on 11/24/2023. 5. Personnel involved were subject to disciplinary action: documentation of terminations and counselling reviewed. 6. Policy and procedure on Elopement and Wandering was reviewed and revised on 11/27/2023. 7. Facility wide staff re-education on Elopement, code green/missing resident and timely reporting initiated on 11/24/23 and completed on 12/13/2023 8. On 11/28/2023 recreation specific education was conducted and included the revision of transporting residents to the auditorium initiated, including reviewing all residents with a wander guard, and communicating with nursing for residents at risk for wandering and being transported off the units 9. On 11/24/2023 implemented a Security specific in-service regarding elopement prevention and reporting. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335653	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER Menorah Home & Hospital for Aged & Infirm		STREET ADDRESS, CITY, STATE, ZIP CODE 1516 Oriental Blvd Brooklyn, NY 11235	

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(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	10. Wander guard lists distributed to all departments. 11. Additional elopement risk binder issued to the guard booth. 12. Nursing staff reviewed all other residents that may be affected, reviewed the plan of care for all residents identified as wanderers, audits were completed for evaluations on residents at risks for Elopement. 15. On 11/27/2023 and 11/28/2023 an interdisciplinary team meeting was held to review the incident. 16. On 12/21/2023 the Allied security assisted the facility to perform a drill and reenacted the same scenario. 17. Elopement Review incorporated into the 2024 Quality Assurance Performance Improvement 18. On 01/18/2024, the Quality Assurance Performance Improvement core committee met and reviewed the incident plan and prevention. 19. On 02/16/2024, the Elopement incident was reviewed with the full Quality Assurance Performance Improvement committee. 20. The nursing team continues to evaluate newly admitted residents for risk of elopement and reevaluate at least quarterly and as needed 10 NYCRR 415.12(h)(2)