STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335666	A. Building B. Wing	03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bezalel Rehabilitation and Nursing Center	29 38 Far Rockaway Blvd 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 39365 Based on record review and interviews conducted during an Abbreviated Survey (NY00309677 and NY00307950), the facility did not ensure that all alleged violations involving abuse and neglect,were reported immediately, but not later than 2 hours after the allegation was made to the State Survey Agency. Additionally, the facility did not ensure that the results of all investigations were reported to the State Survey Agency within 5 working days of the incident. This was evident in 3 of 3 residents (Residents #1, #2, #3) sampled for abuse. Specifically, 1.) On 01/30/2023 at approximately 4:30 am, Resident #2 was observed kissing and inappropriately touching Resident #1. An initial report was made to the New York State Department of Health on 01/30/2023 at 3:12 pm. The facility did not submit a Follow-up Investigation Report within 5 working days of the incident. 2.) On 01/03/2023 at approximately 3:55 pm, Resident #3 eloped from the facility. An initial report was made to the New York State Department of Health, but a Follow-up Investigation Report was not submitted by the facility within 5 working days of the incident. The findings are: A Dear Nursing Home Administrator Letter (DAL: NH 22-20) dated 10/18/2022 regarding Facility Incident Reporting System stated that the notice was to inform the Administrator of changes in reporting of nursing home facility incidents as detailed in QSO-22-19-NH and effective on 10/24/2022. The guidance stated that in addition to an initial facility incident report that must be submitted following reporting timelines, nursing homes must submit to the New York State Department of Health the results of the facility investigation. Within 5 business days of the incident, the facility must provide, in its report, sufficient information to describe the results of the investigation, and must indicate any corrective action(s) taken if the allegation was verified. The facility should include any updates to information provided in the initial report and the following additional information, including, but are not limited to, the following: 1. Additional/Updated information related to the reported incident, 2. Steps taken to investigate the allegation, 3. A conclusion, 4. Corrective action(s) taken, and 5. The name of the facility investigator. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A facility policy titled Department of Health Facility Incident Reporting Guidelines dated 10/24/2022 stated that alleged violations are to be reported to the required individuals (e.g.: Administrator/Designee) immediately but no later than 2 hours after the initial allegation is made. The results of the investigation need to be reported within five (5) working days of the incident to the appropriate State survey agency. The policy defined alleged violations as a situation or occurrence that was observed or reported by a staff member, resident, relative, visitor, or other but has not yet been investigated and, if verified, could demonstrate noncompliance with the federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown sources and misappropriations of resident's property. 1.) Resident #1 was admitted to the facility with diagnoses of Dementia, Anxiety Disorder and Mood Disorder. The Minimum Data Set assessment dated [DATE] documented Resident #1 had severely impaired cognition. Resident #2 was admitted to the facility with diagnoses of Parkinson's Disease, Lewy Body Dementia, and Hemiplegia and Hemiparesis following Cerebral Infarction. The Minimum Data Set, dated dated dated [DATE] Resident #2 had intact cognition. A nurse's note dated 01/30/2023 at 2:50 pm by Registered Nurse Supervisor #2 documented that the writer received a report that Resident #2 was sexually inappropriate towards Resident #1. Resident #2 was found lying next to Resident #1. Resident #2 was kissing Resident #2's cheeks and was touching their breast. A Facility Investigation Summary dated 02/03/2023 documented on 01/30/2023 at approximately 4:30 am, Resident #2 was found in Resident #1's room. Resident #2 was noted kissing and inappropriately touching Resident #1. A Nursing Home Facility Incident Report documented that the incident report was submitted to the New York State Department of Health on 01/30/2023 at 3:12 pm. During an interview on 03/13/2024 at 4:13 pm, the Director of Nursing stated that on 01/30/2023 at 5:00 am, Registered Nurse Supervisor #1 notified them that Resident #2 was kissing and touching Resident #1's breast area. The Director of Nursing stated they were aware that abuse allegations must be reported immediately but not longer than 2 hours to the New York State Department of Health. The Director of Nursing stated that the Administrator was responsible for reporting the allegations. During an interview on 03/13/2024 at 4:30 pm, the Administrator stated they were responsible for reporting incidents to the Department of Health. They stated that the Director of Nursing notified them on 01/30/2023 at 12:10 pm that Resident #2 was found kissing Resident #1. The Administrator stated they reported the incident to the Department of Health on 01/30/2023 at 3:12 pm. The Administrator stated that they were aware that the abuse allegation should have been reported within two hours, but the nature of the incident was unclear. The Administrator stated they reported the incident right away when they arrived at the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a subsequent interview on 03/15/2024 at 12:15 pm, the Administrator stated they did not submit a 5-day Follow-up report because the acknowledgment email they received for the Initial report did not ask them to submit a Follow-up report. The Administrator stated they were following the instructions on Frequently Asked Questions on Facility Incident Reporting that was effective on 10/24/2022, it stated that the facility acknowledgement email will indicate whether an investigative report is necessary, the link to the report will be included in the email. 49169 2.) Resident #3 was initially admitted to the facility on [DATE] with diagnoses of Dementia, Urinary Tract Infection, and Hypothyroidism. The Minimum Data Set, dated dated dated [DATE] documented Resident #3 had severely impaired cognition. A Nurse's note by the Director of Nursing dated 01/01/2023 at 9:19 pm documented they were informed by the Nurse Supervisor at approximately 5:18 pm that Resident #3 was nowhere to be found after Code M was completed. Review of the facility camera was immediately initiated. It was noted that the Resident left the facility at the front door together with non-related visitor at approximately 3:55 pm. The wander alert device alarm door sounded but was released after 15 seconds delay for safety reasons. Resident #3 was able to exit through the door. The facility Investigation Summary dated 01/05/2023 documented that at approximately 5:18 pm, the Director of Nursing received a call from the Registered Nurse Supervisor who reported that Resident #3 was missing. A review of the facility camera was done, and it was noted that Resident #3 exited the facility at approximately 3:55 pm with non-related visitors. The facility concluded there was no reasonable cause to assume abuse, neglect or mistreatment occurred. During an interview on 03/20/2024 at 2:40 pm, the Director of Nursing stated they were required to report immediately upon learning of alleged incidents to the Department of Health. They stated that the email confirmation on initial submission would notify them to submit a 5-day Follow-up report to the Department of Health. For this incident, the email did not instruct them to submit a 5-day Follow up report. During an interview on 03/18/2024 at 11:52 am, the Administrator stated they helped the Director of Nursing to investigate and submit the report to the New York State Department of Health. They stated that the 5-day Follow-up report was not submitted because the email confirmation they received for the Initial report did not ask them to. The Administrator stated they were following the instructions on Frequently Asked Questions on Facility Incident Reporting that was effective on 10/24/2022, it stated that the facility acknowledgement email will indicate whether an investigative report is necessary, the link to the report will be included in the email. 10 NYCRR 415.4(b) (2)

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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** 49169 Based on staff interviews and record review during an Abbreviated Survey (NY00307950), the facility did not ensure each resident received adequate supervision to prevent elopement. This was evident in 1 of 3 residents (Resident #3) sampled for elopement. Specifically, on 01/01/2023, Resident #3, who was severely cognitively impaired and had a wander alert device in place, left the building undetected through the front door at 3:55 pm. Resident #3 was located by the Registered Nurse Supervisor on 01/01/2023 at approximately 8:13 pm with family members walking towards the emergency room in close proximity to the facility. The findings are: The facility's policy on Elopement with a review date of 01/2019 stated that the facility will ensure that the safety of residents who wander is maintained, and that elopement is prevented. Resident #3 was initially admitted to the facility on [DATE] with diagnoses of Dementia, Urinary Tract Infection, and Hypothyroidism. The Minimum Data Set, dated dated dated [DATE] documented Resident #3 had severely impaired cognition. A Nursing Elopement Risk assessment dated [DATE] documented Resident #3 was at risk for elopement as evidenced by wandering on the unit. A care plan on behavior symptoms related to wandering was initiated on 12/30/2022. The care plan documented Resident #3 exhibited wandering behavior as evidenced by wandering on unit and attempting to leave the floor on 12/29/2022. A care plan on wandering/elopement was initiated on 12/30/2022. The facility intervention included to check wander alert device to left lower extremity every shift for function and placement. A nurse's note dated 01/01/2023 at 9:19 pm by the Director of Nursing documented they were informed by the Nurse Supervisor at approximately 5:18 pm that Resident #3 was nowhere to be found after Code M (facility's code for missing person) was completed. Review of the facility camera was immediately initiated, and Resident #3 was noted leaving the facility at the front door together with non-related visitor at approximately 3:55 pm. The wander alert device alarm door sounded but was released after 15 seconds delay for safety reasons, resident was able to exit through the door. A Certified Nursing Assistant #2's written statement dated 01/01/2023 documented at approximately 3:30 pm, at the beginning of their shift, Resident #3 was in their room. At approximately 3:50 pm, they saw Resident #3 with a visitor going on the elevator. They did not approach Resident #3 because Resident #3 was with a visitor. At dinner time, staff realized Resident #3 was not in their room. Resident #3 was missing. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Investigation Summary dated 01/05/2023 documented that Resident #3 was provided care at approximately 1:00 pm and was left seated in their room at 1:30 pm. The Registered Nurse Supervisor saw Resident #3 seated in their room during rounds at 3:20 pm. A review of the facility camera was done and noted Resident #3 exited the facility at approximately 3:55 pm with non-related visitors. At approximately 8:13 pm, a call was received from the Registered Nurse Supervisor that Resident #3 was found in the hospital with their family and remained in the emergency room for evaluation. The facility concluded there was no reasonable cause to assume abuse, neglect, or mistreatment occurred. The summary documented that knowledge of Resident #3's behavior provides enough evidence to justify ruling out abuse, neglect, and mistreatment. A Wandering/Elopement Monitoring Sheet dated 01/01/2023 documented that Resident #3 was last seen in their room at 4:00 pm. There was no documentation of half hourly checks after 4:00 pm. A wander alert device list with resident photographs dated 12/29/2022 revealed that Resident #3's name and photo were not listed. During an interview on 03/13/2024 at 2:00 pm, Registered Nurse #1 stated at around 3:40 pm they saw Resident #3 standing at the nurses' station with a bag of clothes. Registered Nurse #1 stated Certified Nursing Assistant #1 assisted the Resident back to their room. Registered Nurse #1 stated they were informed by the Registered Nurse Supervisor #1 at 5:00 pm that Resident #3 was not in their room. During an interview on 03/15/2024 at 10:51 am, Certified Nursing Assistant #3 stated they were serving dinner with Certified Nursing Assistant #1 at around 4:30 pm, when they notice Resident #3 was not in their room. Certified Nursing Assistant #3 stated they told the charge nurse and the supervisor and started searching the unit for Resident #3 and Code M for missing person was called. During an interview on 03/13/2024 at 1:25 pm, Security Guard #1 stated that on 01/01/2023 at approximately 1:25 pm, the alarm for the wander alert system was activated. There were visitors leaving the facility at that same time, and there was a resident passing by the lobby with a wander alert device. Security Guard #1 stated they were not aware that Resident #3 exited with the visitors. They were not aware of Resident #3 being an elopement risk because their name and picture was not on the wander alert device list. During an interview on 03/15/2024 at 11:00 am, Registered Nurse Supervisor #1 stated they drove to the nearest hospital and saw Resident #3 with 3 females walking towards the emergency room . During an interview on 03/13/2023 at 2:40 pm, the Director of Nursing stated that on 01/01/2023, the wander alert alarm activated when Resident #3 approached the entrance door. At the same time there was another resident passing by who was also wearing a wander alert device. They stated that Resident #3 was located on the same day at about 8:00 pm. During a follow-up interview on 03/20/2024 at 2:40 pm, the Director of Nursing stated that Resident #3 was on half-hourly checks and that the Certified Nursing Assistant might have signed 4:00 pm in error. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 03/18/2024 at 11:52 am, the Administrator stated that Registered Nurse Supervisor #1 notified them on 01/01/2023 at approximately at 5:18 pm that Resident #3 was missing from the facility. At approximately 8:13 pm, they were informed by the Registered Nurse Supervisor #1 that Resident #3 had been found in the hospital emergency room with family members and that Resident #3 was in stable condition. The Administrator stated they concluded in their investigation that abuse, neglect and mistreatment were ruled out based on Resident #3's behavior history. 10 NYCRR 415.2 (h) (2)