STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335724	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silvercrest	144 45 87th Avenue Jamaica, NY 11435

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. 43285 Based on observation, record reviews, and interviews, conducted during an abbreviated survey NY00334448), the facility failed to ensure that a resident right to be informed, in advance, of changes to their plan of care. This was evident for 1 out of 6 residents (Resident #2) sampled. Specifically, a Nursing Progress Note dated 05/19/2024 at 9:16pm documented Resident #2 was an elopement risk, and a wander-guard (elopement prevention system transmitter) was placed on the left side of Resident #2's motorized wheelchair. During an interview on 08/01/2024 at 2:30pm, Resident #2 stated that they were not aware that the facility had placed a wander-guard device on their motorized wheelchair until 06/07/2024 when they attempted to exit the main entrance door in the lobby. Resident #2 stated, at no time where they notified that they were an elopement risk and that they did not consent to wearing a wander-guard device. The findings are: The facility's Policy for Residents Rights and Responsibilities dated 09/01/2021, documented all residents/patients/designated representatives will be given a copy of the Resident's [NAME] of Rights (Attachment 1) prior to or upon admission, and as indicated thereafter. In addition, they will receive and explanation of these rights and be fully advised of their rights and responsibilities as residents/patients of the facility. Attachment I (9) of the policy documents that Resident to be treated with courtesy, fairness, consideration, respect and full recognition of his dignity and individuality including privacy in treatment and in care for their personal needs. An Elopement and Wandering Policy last dated 11/10/2022 was reviewed. Section 2 mentioned placing an electronic elopement prevention system transmitter (bracelet) on resident. Placed on wheelchair only if placement on body is not possible. Resident #2 was admitted to the facility with diagnoses including Spinal Cord Injury, Quadriplegia, Anxiety, and Pressure Ulcer. The Minimum Data Set (an assessment tool) dated 12/12/2023 documented Resident #2 had a Brief Interview of Mental Status (used to determine attention, orientation, and ability to recall information) and scored of 15 associated with intact cognition. A Care plan for Resident/Family Education dated 04/20/2021 was reviewed. The care plan was last updated on 03/12/2024. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence that Resident #2 or their family member was educated on changes in Resident #1's plan of care on 05/19/2024. A Psychiatry Progress Note dated 02/23/2024 documented Resident #2 does not have full capacity to make sounds complex medical care decisions. Resident #2 was guarded, paranoid, and jeopardizing their (Resident #2) health. An Exit Seeking/Wandering Evaluation form dated 05/19/2024 documented that Resident #2 was not disoriented to place and had no impairment in decision-making. A Physician's Order dated 05/19/2024 documented Elopement Precautions, wander-guard in place. A nursing progress note dated 05/19/2024 at 9:16 pm documented elopement risk, wander-guard to left side motorized wheelchair. An Elopement and Wandering Care Plan dated 05/19/2024 documented Resident #2 was at risk for elopement related to verbalized intent and left facility without permission. Resident #2 was followed by staff for about 45minutes. A Secure Care Transmitter placed on wheelchair. There was no documented evidence that Resident #1 was notified of their elopement status or that a Secure Transmitter bracelet would be placed on their wheelchair. During a telephone interview on 08/01/2024 at 2:30 pm, Resident #2 stated that they were not aware that they were an elopement risk and that a wander guard was hidden on their motorized wheelchair. Resident #2 stated that they became aware of the wander guard on 06/07/2024 when they attempted to exit the main entrance door in the lobby. Resident #1 went on to say that the alarm was activated, and the door was locked. Resident #2 stated that they did not receive any education on the wander-guard or consented to wearing one. Resident #1 stated that their rights to move about freely was restricted. Resident #2 stated that they did not receive any education on the wander-guard and how the wander-guard works. During an interview on 08/01/2024 at 3:00 pm, Registered Nurse Supervisor #2 stated that prior to 06/07/2024, Resident #2 was deemed at risk for elopement and a wander-guard was placed on Resident #2's motorized wheelchair. Registered Nurse Supervisor #2 stated that it is facility's protocol that when a resident is deemed an elopement risk, an elopement assessment is performed, the Medical Doctor is notified, a physician's order is obtained, and a wander-guard is placed on the resident. Registered Nurse Supervisor #2 stated that on 05/19/2024, Resident #2 left the facility unsupervised and staff members had to follow Resident #2 into the community and brought Resident #2 back into the facility. Registered Nurse Supervisor #2 stated that Resident #2 was assessed and deemed at risk for elopement. Registered Nurse Supervisor #2 went on to say that Resident #2's behavior was erratic and unsafe, and that Resident #2 was not given a choice to wear a wander-guard. Registered Nurse Supervisor #2 stated that Resident #2 was evaluated by telehealth Psychiatrist, who stated that Resident #2 has no capacity for decision-making. Registered Nurse Supervisor #2 stated that Resident #2 was told that a wander-guard would be placed on their motorized wheelchair to alert the facility staff when Resident #2 is leaving the facility. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/01/2024 at 3:28 pm, the Director of Nursing stated that Resident #2 has behavioral issues and has attempted to leave the facility without supervision. The Director of Nursing stated that Resident #2 was assessed to be at risk for leaving the facility and was at high risk for being a danger to themself. The Director of Nursing stated that a wander-guard was applied to Resident #2's motorized wheelchair for Resident #2's protection, and to alert the staff. The Director of Nursing stated that Resident #2 was not given a choice to wear a wander-guard because of Resident #2's erratic behavior. The Director of Nursing stated that Resident #2 instructed the facility not to inform their family on any matters that related to them and did not consent to wearing a wander guard. 10 NYCRR 415.3