STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335780	A. Building B. Wing	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa Promesa	308 East 175 Street Bronx, NY 10457

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 - 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** Based on observation, record review, and interviews during an Abbreviated Survey (NY00380952), the facility failed to ensure that a resident, identified as an elopement risk based on a history of previous elopement attempts, received adequate supervision to prevent elopement from the facility. This was evident for one (1) of eight (8) residents sampled (Resident #1). Specifically, on 05/16/2025 at 10:12 AM, Resident #1, who was assessed as cognitively impaired and at risk for elopement, who had a Wander Alert Device on their left ankle, exited the building undetected. Interview revealed Security Guard #1 heard a beeping sound and was not aware that it was the Wander Alert Alarm. Security Guard #1 did not investigate the beeping sound, did not identify if a resident exited the facility, did not search the lobby, and did not notify any staff. Security Guard #1 stated they were not educated on steps to be taken when the Wander Alert system was activated. Resident #1 did not return to the facility and their location remained unknown. This resulted in Immediate Jeopardy with the potential for serious harm to eight (8) residents who were at risk for elopement. The findings include: The facility's Wander Guard Policy dated 10/10/2023, documented the facility shall utilize wander management systems and devices to promote residents' safety while maintaining the least restrictive environment to protect the rights and dignity of the resident. The facility's Elopement Prevention and Missing Resident Policy dated 12/04/2024, documented the facility shall ensure the accountability and safety of each resident/client admitted to the facility while protecting their rights as a nursing home resident/client. There was no documented evidence of education for staff, including security guards, on what to do if the Wander Alert system was activated. Resident #1 was admitted to the facility from the hospital with diagnoses that included Deafness, communicable disease related Dementia, and Altered Mental Status. The Hospital Discharge summary dated [DATE], documented Resident #1 did not have capacity and was frequently requesting to go home or to go to work and Resident #1 was discharged from the hospital on [DATE] with an arm bracelet on to alert the facility of the risk for elopement. A Nursing Baseline Care Plan dated 05/15/2025 documented Resident #1 was at risk for elopement. (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 - Few	A Comprehensive Care Plan titled Behavior Symptoms: Wandering/Elopement dated 05/15/2025, documented interventions to ensure proper placement of wander guard/ankle alert, check for any malfunction, inform the staff of resident's elopement risk, and forward the resident's picture with room and floor to the security desk. A Visual Monitoring Form dated 05/16/2025, documented Resident #1 was being monitored hourly from 12:00 AM and was last seen at 10:00 AM. The facility's investigation dated 05/20/2025 documented on 05/16/2025 at 11:00 AM, during visual checks, Certified Nursing Assistant #1 noticed that Resident #1 was not in their room or on the unit. Certified Nursing Assistant #1 was directed by Licensed Practical Nurse #1 to search the common areas. When Resident #1 was not found the Administration was notified, and Code Yellow (missing person alert) was announced at 11:30 AM. The facility's investigation summary documented that the video surveillance footage was reviewed by the Director of Nursing, the Administrator, the Director of Social Services, and the Assistant Administrator. The camera in the main lobby showed at 10:12 AM Resident #1 stepped out of the elevator and made a hand gesture to Security Guard #1 as they walked towards the front door. Security Guard #1 clicked and held the buzzer to release the door, and Resident #1 exited the building. The facility discovered Security Guard #1 pressed the buzzer before the Wander Alert device was within range to set the alarm off, therefore, the alarm would not have locked the doors. The facility concluded Resident #1 eloped. A Nursing Note dated 05/16/2025 at 9:29 AM, documented by Licensed Practical Nurse #1 indicated Resident #1 was alert and responsive, able to ambulate and use their phone or wrote on paper to communicate with staff. On 05/16/2025 at 9:29 AM, all due medications were administered. Resident #1 continued to be monitored for risk for elopement/falls, wander alert device on Resident #1's left ankle. At 11:00 AM, staff reported to Licensed Practical Nurse #1 that Resident #1 was not in their room. All staff were alerted, and code yellow was announced. A Nursing Note dated 05/16/2025 at 5:46 PM, by Registered Nurse Supervisor #2 documented at approximately 11:30 AM, staff reported Resident #1 was missing. Code Yellow was announced and a search of all the units began, including around the community and neighborhood, however, the search was unsuccessful. The video surveillance footage was reviewed, and Resident #1 was seen leaving the facility through the main lobby front door. On 05/20/2025 at 9:53 AM, the facility video surveillance footage was reviewed with the Administrator. The surveillance footage showed that on 05/16/2025 at 10:10 AM (real time), Resident #1 exited their room wearing a scarf on their head, sweatpants, a sweater and was holding a black bag. Elevator camera #1 showed that at 10:12 AM, Resident #1 entered the elevator alone, put on a mask and exited the elevator in the lobby. A camera titled Lobby Desk showed that at 10:12 AM, Resident #1 exited the elevator, waved to Security Guard #1 and exited through the main lobby of the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 05/20/2025 at 1:11 PM, Certified Nursing Assistant #1 stated they were assigned to Resident #1. They monitored Resident #1 hourly and documented on the monitoring form. They stated they received a report from the outgoing nurse who informed them that Resident #1 stated they wanted to go home. Certified Nursing Assistant #1 stated they did not observe the wander alert device on Resident #1's ankle when they took Resident #1's vital signs (pulse, respiration and temperature) at approximately 9:30 AM. They stated they went to Resident #1's room to check on them at around 11:00 AM (exact time unsure) and Resident #1 was not in their room, and they were unable to locate Resident #1. They stated that they reported it to Licensed Practical Nurse #1, and a search for Resident #1 was initiated. During an interview on 05/20/2025 at 3:06 PM, Registered Nurse Supervisor #1 stated they initiated the admission process for Resident #1 on 05/15/2025 at 12:58 PM, at which time, Resident #1 expressed wanting to go home. They stated Resident #1's hospital records were reviewed by Nurse Practitioner #1, and it was documented that Resident #1 had eloped from somewhere else. Therefore, Resident #1 was placed as an elopement risk. During an interview on 05/20/2025 at 3:30 PM, the Director of Nursing stated they were informed on 05/16/2025 at 11:30 AM that Resident #1 was missing. They stated an announcement for Code Yellow was initiated and a search was conducted. They stated Resident #1 was at risk for elopement and their investigation concluded that Resident #1 had eloped from the facility. They stated the Director of Social Services spoke with Resident #1's family on 05/17/2025 at 8:00 PM and was informed by the family that Resident #1 was in New Jersey. The Director of Nursing stated as far as they knew Resident #1 remained in New Jersey and their whereabouts in New Jersey remained unknown. During a telephone interview on 05/21/2025 at 11:10 AM, Security Guard #1 stated when Resident #1 exited the elevator they thought Resident #1 was an employee because Resident #1 waved goodbye to them in the same manner the employees usually waved goodbye. Security Guard #1 stated after Resident #1 exited the building they heard a beeping sound, and they did not know what the beeping sound was. Security Guard #1 stated that they asked someone (unsure of person) if they knew what the beeping sound was and the person said no. Security Guard #1 stated that the beeping sound stopped by itself, they did not disengage the alarm. They stated they did not check the premises, they just stayed behind the desk. During an interview on 05/21/2025 at 11:12 AM, the Director of Social Services stated that on 05/15/2025 between approximately 5:30 PM and 6:00 PM, they received a call from Nurse Practitioner #1 requesting they speak to Resident #1 because Resident #1 did not want to stay in the facility. The Director of Social Services stated they spoke to Resident #1 and encouraged Resident #1 to stay. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 05/22/2025 at 11:56 AM, the Medical Director stated they received a call from Nurse Practitioner #1 on 05/15/2025 sometime during the evening (exact time unsure) stating Resident #1 expressed they wanted to go home. The Medical Director stated Resident #1 had dementia, a communicable disease, and a history of homelessness and the plan was to put Resident #1 closer to the nurse's station, place the facility's wander alert device on them, and monitor them hourly. They stated they instructed Nurse Practitioner #1 to send Resident #1 to the hospital if Resident #1 attempted to leave the facility. They stated the Psychiatrist was called to assess Resident #1's medication. The Medical Director stated they received a text message on 05/16/2025 at 11:31 AM from the Director of Rehabilitation who stated Resident #1 was missing, and law enforcement was called. They stated they were not provided with the details on how Resident #1 left the facility. They stated they spoke with the Director of Social Services, who reported to them that Resident #1's family was contacted and informed the facility that Resident #1 was in New Jersey. During an interview on 05/28/2025 at 2:01 PM, the Administrator stated Resident #1 was triggered as an elopement risk based on the documentation provided by the hospital, therefore, a wander alert device was placed on Resident #1's ankle (unsure of which ankle). They stated on 05/16/2025 at 11:30 AM, they were informed via text message that Resident #1 could not be located, and Code Yellow was initiated via the intercom at 11:33 AM. They stated that Security Guard #1 was new to the facility and was not trained on the wander Alert system. The Administrator stated Security Guard #1 reported to them that they did not see any resident leave, nor did they hear any activated door alarm. The Administrator stated Resident #1's family was contacted after Resident #1 could not be located and Law Enforcement were also notified. They stated they called Resident #1 multiple times via facetime. The Administrator stated Resident #1 answered one of the calls at 1:42 PM on 05/16/2025 then disconnected the call. They stated Resident #1's picture was not obtained because they were new to the facility. The Administrator stated they spoke with an officer from New Jersey [NAME] Police Department on 05/18/2025 and had not followed up with them since; Resident #1's whereabouts remained unknown. They stated the Director of Social Services documented that they last contacted Resident #1 or Resident #1's family on 05/17/2025. Immediate Jeopardy was identified, and the Administrator was notified on 05/23/2025 at 10:12 AM. An acceptable immediate corrective action plan from the facility was received on 05/23/2025 at 3:42 PM. Immediate Jeopardy was removed prior to survey exit on 05/28/2025 based on the following corrective actions taken by the facility: 1) Facility re-educated the Nursing staff regarding monitoring residents at risk for elopement and using the wander alert device. 2) Facility educated all staff regarding elopement prevention, which includes, adequately supervising the residents every thirty minutes and/or hourly, checking wander alert device placement and functionality, conducting head count of the residents by the nursing staff at the beginning and end of shift to ensure location of the residents who are at risk for elopement. 3) Facility educated the Security Guards on visitation and elopement policy and ensuring that staff present their identification badge before releasing the locking mechanism allowing them to leave the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4) Facility has conducted chart audits of eight (8) residents at risk for elopement and using wander alert devices to ensure that the residents were assessed, and elopement care plans were updated. 5) Facility will continue to monitor and discuss residents at risk for elopement during their weekly comprehensive care plan meeting every Wednesday. 6) All Security Guards will receive in-service education on Visitation and Elopement policy. Security Guards must ensure that all visitors log in and out when visiting. Visitors are to be given a name tag sticker that must always remain in view while in the facility. Security Guards must ensure that residents who are leaving the building, for example, for out on pass, clinic visits or transfer to the hospital have their arm band on. They must also check employee's identification badge prior to buzzing the door. 7) The facility reviewed their Policies and Procedures on Elopement Prevention and Missing Resident, Visitation and Wander Guard Functioning Test and revised them on 05/23/2025. 8) The facility provided an audit tool to monitor wander alert device functionality and placement, visitors' signage, weekly alarm check, armband placement and alarm checks for the security door. As of 05/28/2025, the following staff received in services on elopement prevention, wander alert device and visitation. Security Guards- 9 of 12 =75 %, Registered Nurse-12 of 13=92%, Licensed Practical Nurses- 8 of 11 = 72%, Certified Nursing Assistants-32 of 39 =82 %, Administration staff - 13 of 15 =86 %, Housekeeping staff - 8 of 8 =100 %, Unit Clerk - 3 of 3 =100 %, Medical staff- 4 of 6 = 66 %, Dietary staff -7 of 9 =77%. Staff who are out of work will attend the in service prior to reporting to their workstation. 10 NYCRR 415.12(h)(2)