

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335808	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/20/2024
NAME OF PROVIDER OR SUPPLIER  Hempstead Park Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  800 Front Street Hempstead, NY 11550	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 33316</p> <p>Based on observation, record review and interviews during an abbreviated survey (Case #NY00321006) the facility failed to ensure that a resident identified as an elopement risk received adequate supervision to prevent elopement from the facility. This was evident in 1 out of 3 residents reviewed for elopement (Resident #1). Specifically, Resident #1 who was cognitively impaired, was initially assessed as an elopement risk on 07/07/2022. At that time, the resident was placed on 15-minute monitoring, and a wander alert device was placed on the left ankle. Subsequently, on 02/19/2024 at 4:54 PM, Resident #1 walked through the front door undetected, and was returned to the facility by relatives and local police on 02/20/2024 at 12:57 PM.</p> <p>This resulted in Immediate Jeopardy with the likelihood for a serious adverse outcome to Resident #1 and 31 other residents who were at risk for elopement.</p> <p>The findings include.</p> <p>Resident #1 was admitted to the facility on [DATE] with a diagnosis of non-Alzheimer's dementia (defined as dementia associated with cerebrovascular disease, dementia associated with extrapyramidal features, and the frontotemporal dementias). The Minimum Data Set (MDS) dated [DATE] quarterly assessment documented a Brief Interview for Mental Score (BIMS) of 5/15, representing impaired cognition. The MDS further documented resident walked in corridor on and off unit, and the use of wander/elopement alarm.</p> <p>The policy titled Elopement Prevention/Wandering Behavior Management dated 08/12/2022 documented it is the policy of the facility to utilize all possible measures to maintain the safety and wellbeing of all residents. To have a system and tools in place to do all that is reasonable to identify and prevent unsafe wandering and/or elopement and to act quickly and prudently should either occur.</p> <p>The Comprehensive care plan updated 12/27/2023 titled Elopement documented Resident is at risk for elopement secondary to dementia. Interventions included: monitor whereabouts and document in the visual observation logbook, check function of secure bracelet every night.</p> <p>The physician order was renewed on 02/12/2024 and documented visual check every 15 minutes for safety.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>The visual monitoring sheet documented Resident #1 was last seen on unit 3-hallway on 02/19/2024 at 4:45 PM by Certified Nursing Assistant #3. There were no further entries on the monitoring sheet for this resident.</p> <p>The review of the video surveillance revealed that on 02/19/2024 at 4:54 PM, Resident #1 was seen walking from the double doors which separate the lobby from the resident elevator, passing the main security desk and exiting the building. The security guard was seen disarming the system with a brief exchange with Resident #1, a male, and female visitor and then returned to the desk.</p> <p>The facility investigation dated 02/19/2024 included a statement from Security Guard #1 and documented Resident #1 walked past the security desk with 2 visitors. Security Guard #1 stated they had never seen Resident #1 before and did not know they were a resident. Security Guard #1's statement further documented the alarm went off and they turned off the alarm.</p> <p>The Timeline of events was as follows:</p> <p>4:45 PM Resident #1 was last seen on seen on unit.</p> <p>4:54 PM Resident #1 was seen leaving the facility via video surveillance.</p> <p>6:15 PM Dinner tray was served, Resident #1 was noted to be missing, unit was searched.</p> <p>6:30 PM Code Honeymoon (the facilities overhead code word for elopement) was called.</p> <p>6:40 PM Facility administration notified.</p> <p>6:45 PM local Police department notified.</p> <p>6:50 PM Resident Representative notified.</p> <p>The temperature reading on 02/19/2024 for [NAME] New York, from the [NAME] F [NAME] international airport station, was 41 degrees at 4:51 PM. The facility is located on a main street with 2-way traffic.</p> <p>During an interview conducted on 03/13/2024 at 11:30 AM with Resident #1 they stated they walked to see mom. They further stated they had a sweater on because it was cold outside.</p> <p>During an Interview conducted on 03/13/2024 at 4:00 PM, Certified Nursing Assistant #3 stated that all Nursing Assistants are responsible for monitoring the residents and completing the visual monitoring logbook. They further stated that on 02/19/2024 at approximately 6:00 PM, they noticed Resident #1 was not in their room when they went in with the dinner tray. They notified the nurse. Certified Nursing Assistant #3 stated Resident #1 visual check was not completed after 4:45pm because the unit was busy that night.</p> <p>(continued on next page)</p>		

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