STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335487	A. BUILDING _____ B. WING _____	07/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST JOHNLAND NURSING CENTER INC	395 SUNKEN MEADOW ROAD KINGS PARK, NY 11754

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 **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 observations, interviews, and record reviews during an abbreviated and extended survey (Complaint number NY 869) conducted on 7/28/20-7/29/20, the facility failed to have an effective system in place to monitor and supervise residents at risk for elopement and unsafe wandering behaviors for one (Resident #1) of six residents reviewed for Elopement. Specifically, Resident #1 with impaired cognition, a history of elopement, and exhibited exit seeking behaviors was assessed at risk for elopement and required enhanced (1:1 in line of sight) supervision. The staff did not supervise the resident as directed, and the resident was able to pass two alarmed doors to successfully elope from the facility. The resident was found 1 hour and 40 minutes later approximately 2.8 miles away walking down the road. This resulted in potential for serious harm for 34 residents at risk unsafe wandering and elopement that is an Immediate Jeopardy. The findings were: The facility's policy titled Enhanced Supervision dated 1/2019 documented enhanced supervision is an approach for meeting the individualized care needs of residents with behavioral symptoms that potentially put them at risk of injuring themselves or others. The following guidelines will be used for this determination: - One to one supervision - one staff member will be in direct contact with the resident at all times. -Line of sight observation - the resident will be in the sightline of a designated staff member and/or designated person at all times. The staff member responsible may be watching other residents at the same time and does not have to be in direct proximity to the resident being observed but should be close enough to intervene if it becomes necessary The nurse informs all direct caregivers that enhanced supervision is in effect for a resident, starts the enhanced flow sheet, and adds the information to the resident care profile. The direct caregiver observes the resident at the intervals prescribed on the enhanced documentation flow sheet, completes the enhanced supervision flow sheet, and notifies the nurse of any unexpected changes in the resident's behavior. The facility's policy titled Roam Alert System and Protocol dated 2/2020 documented elopement is defined when a resident leaves the premises or a safe area without authorization (i.e an order for [REDACTED]. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS-an assessment tool) dated 3/12/20 documented the resident's cognitive skills for daily decision making as moderately impaired. The physician's orders [REDACTED]. The Wandering/Elopement Evaluation Guide (Elopement Assessment) dated 3/6/20 documented the resident was resistant to the placement and had a history of [REDACTED]. The Nurse's Progress Notes (NPN) dated 3/10/20 at 4:06 PM documented the resident was attempting to exit the unit, the resident stood up from wheelchair pushing the nurse and staff out of the way, forcing the exit doors to open. The resident was not easily re-directed. The resident was sent to the hospital for evaluation and a Computerized Tomography (CT) Scan of the head. The NPN dated 3/11/20 at 10:40 PM by Licensed Practical Nurse (LPN) #2 documented the resident returned from the emergency room at 6 PM. Enhanced supervision is in progress, the resident has no behaviors. 1:1 direct line of sight. The 24-hour report dated 3/11/20 documented that the resident came back from the hospital, and was placed on enhanced supervision, 1:1 direct line of sight. The PO dated 3/11/2020 documented, roam alert for safety awareness, check every shift for placement of the device. The CCP titled Behavioral Symptoms dated 3/11/20 documented the resident was exit seeking and knows the area, will attempt to exit when staff is not around. The resident is also resistant to care and redirection. The Enhanced Supervision Flow Sheet dated 3/11/20 through 3/12/20 documented Resident #1 was on 1:1 direct line of sight supervision. The flowsheet documented, at 6:00 AM the resident was dressed and placed in the hallway. At 6:15 AM the CNA (#1) documented he gave (the resident) to nurse. The 7:00 AM and 7:30 AM entry documented that the resident was missing. The facility Investigation Summary undated and unsigned, documented, on 3/10/20 the Resident was exhibiting exit seeking behaviors and was difficult to redirect. The resident was sent to the hospital for evaluation and head CT returned on 3/11/20 and was direct line supervision was initiated. On 3/12/20 the resident was last seen at 6:40 AM by RN #1. At 6:50 AM the roam alert alarm on the resident's unit sounded followed by another exit (perimeter) door alarm at 6:51 AM. The ADON and RNS #1 responded to the alarms. Code green was called. The resident was located 2.8 miles away at 8:30 AM. Small abrasions to the right-hand knuckles and right knee observed during a skin check. The RN Unit Manager (RNUM) was interviewed on 7/28/20 at 3:21 PM, she stated Resident #1 exhibited exit seeking behaviors. The RNUM had advised the evening shift LPN #2 to place the resident on enhanced 1:1 supervision if the resident returned from the emergency room . The resident came back from the hospital within 24 hours was placed on enhanced supervision, 1:1 direct line supervision. RNUM stated that 1:1 direct line of sight required staff to monitor the resident all the time. The 3:30 PM -11:30 PM shift LPN #2 was interviewed on 7/29/20 at 4:13 PM and she stated Resident #1 came back from the hospital on her shift on 3/11/20. She was informed by the RN (name not recalled) to place Resident #1 on enhanced supervision and staff to monitor the resident at all times. LPN #2 stated she reported to RN #1 that the resident was on enhanced 1:1 direct line of sight supervision and documented the same in the nursing progress notes, 24-hour report, and the enhanced flow sheet. The 11:30 PM to 7:30 AM shift RN #1 was interviewed on 7/29/20 at 11:08 AM and she stated on 3/11/20 she received a report from LPN #2 to keep a close eye on Resident #1. RN #1 stated she was not aware of the resident's exit seeking behavior. RN #1 stated she did not see or read the enhanced supervision flowsheet and could not recall if she read the 24-hour report. RN #1 stated that she was watching the resident from 6 AM until about 6:35 AM. At 6:35 AM RN #1 went to perform a bladder scan for another resident. She called CNA #1, CNA #1 did not come out of the room, RN #1 left Resident #1 sitting in the hallway. RN #1 stated after the bladder scan when she came out she did not see Resident #1, she heard the perimeter exit door alarm sounding. RN #1 stated she did not hear the roam alert door alarm. She responded to the alarming perimeter door, she did not see Resident #1. The police were informed and found the resident 2 miles away from the facility. The 11:30 PM -7:30 AM shift CNA #1 was interviewed on 7/29/20 at 2:05 PM, he stated he was assigned to Resident #1 on 3/11-3/12/20. He checked Resident #1 every 15-30 minutes. CNA #1 stated he was not aware of the resident's exit seeking behaviors. At approximately 6:00 AM CNA #1 placed the resident in the wheelchair and told RN #1 to monitor the resident. At approximately 6:30 AM, RN #1 told him that she was going to give medications but did not instruct him to monitor Resident #1. CNA #1 stated that he was providing care to another resident and did not hear any alarm sounds. He was told by RN #1 that she was unable to find Resident #1. The 11:30 PM to 7:30 AM shift CNA #2 was interviewed on 7/29/20 at 7:59 AM and stated she worked on 3/11-3/12/20. She was not assigned to Resident #1. After 6:00 AM (not able to recall exact time) CNA #2 stated she was providing care to another resident, and while in resident's room she did not hear a door alarm. When she came out of the room to discard the trash near the nurses' station she heard the unit door roam alert alarming and RN #1 told her that Resident #1 exited the unit. CNA #2 stated she did not receive in-service on Elopement after the incident The Assistant Director of Nursing (ADON) was interviewed on 7/29/20 at 1:33 PM and she stated she was part of the investigation. Resident #1 was supposed to be on the direct line of sight of supervision before the incident because he had exit seeking behaviors. The ADON stated that Resident #1 was not supervised as directed and eloped.

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

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.

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) The ADON stated that the unit door roam alert alarm could only be heard on the unit and in the nursing office monitor. If the staff was in resident rooms or at the other side of the hallways they may not hear the roam alert door alarm. ADON stated that the investigation concluded that the facility had everything in place, the alarms worked. The 11:30 PM to 7:30 AM Registered Nurse Supervisor (RNS) #1 was interviewed on 7/29/20 at 8:28 AM and stated that Resident #1 had exit seeking behaviors. The resident was placed on 1:1 direct line sight supervision indicating that someone should monitor the resident all the time. On 3/12/20 at approximately 6:45-6:50 AM the unit alarm activated indicating Resident #1 breached the roam alert alarm door. RNS #1 responded to the unit and met RN #1 in the hallway. RN #1 said she could not find Resident #1. RNS #1 told RN #1 that the unit alarm was sounding. Upon entry to the unit, she heard the perimeter exit door sound. RNS #1 responded to the exit door alarm, went outside but did not see Resident #1. A code green and 911 was called. The RNS stated that Resident #1 was not supervised (in the line of sight). The unit RN #1 was inside the room conducting a bladder scan and both CNAs were providing care to the other residents. The Finance Director (FD) was interviewed on 7/28/20 at 4:02 PM and he stated on 3/12/20 the resident was missing. The FD assisted in the search and found Resident #1 at approximately 8:30 AM walking briskly 4-5 miles away on the side of the main road. The resident was sweating and breathing heavily. The resident had no hat or jacket on. The Director of Nursing (DON) was interviewed on 7/29/20 at 2:45 PM and stated staff was expected to watch the resident all the time. Resident #1 was not monitored. The DON did not think that involved staff was educated or given disciplinary action. The Administrator was interviewed on 7/29/20 at 6:05 PM and stated she did not conduct the investigation and was not familiar with the investigation enough. No staff was at fault. There was no issue related to Resident #1's supervision. The Administrator was not aware of the resident's supervision status. The Administrator stated that there was no issue with the investigation and nobody needed to be educated or counseled. 415.12(h)(2)