STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335079	A. BUILDING ______ B. WING ______	C 08/26/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD CREST CARE CENTER	**2316 BRUNER AVENUE** **BRONX, NY 10469**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 225		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335079	A. BUILDING ______ B. WING ______	C 08/26/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 225	Continued From page 1 by: Based on interview and record review, the facility did not thoroughly investigate an incident of elopement. This was evidenced in 1 of 10 sampled residents. (Resident #1) This resulted in no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Complaint ID # NY00061483 The findings are: Resident#1 was admitted to the facility on 5/10/07. His diagnoses include Dementia with Behavioral Disturbances, Psychosis, Hypertension, Emphysema/ Chronic Obstructive Pulmonary Disease. As per the Minimum Data Set 2.0 (MDS) dated 5/30/08 the resident has severely impaired cognitive skills for daily decision making, with short and long term memory problems. The MDS also notes that the resident has wandering behavior that occurred daily and was not easily altered. A review of the facility's initial assessment tool titled "Wandering Residents," dated 05/10/07 revealed that resident #1 was assessed upon admission and deemed as a wandering resident. A review of the Comprehensive Care Plan (CCP) dated 05/10/07, titled "Potential for Elopement/Wandering," identified the resident as a wanderer. The interventions included re-direct as needed, encourage the resident to express feelings/need, place wander-guard on the	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335079	A. BUILDING ____ B. WING ____	C 08/26/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD CREST CARE CENTER	2316 BRUNER AVENUE BRONX, NY 10469

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F 225	Continued From page 2 resident's right ankle, monitor on and off the unit. A review of the facility's unsigned, Investigation Summary report dated 08/18/08 reveals that Resident #1 was observed at 7:30PM interacting with visitors and other residents. He was noted missing at 7:55PM and code orange was initiated. The resident was located via telephone call from the facility to the hospital. The facility was informed by the ER that the resident was brought in by EMS. The facility's Administrator escorted the resident back to the facility at 2:00AM. Review of the facility's investigation revealed that a statement was not obtained from the Registered Nursing Supervisor, who was in charge of the facility on the evening of the elopement, and who was also in charge of monitoring the camera screen in her office. The facility ' s surveillance video was reviewed on 08/19/08 at 12:30PM. It revealed that the resident exited the facility through the front door of the facility at 7:35PM. He was seen pushing on the release bar of the door without any delays. No one was seen in the lobby. During interview with the Director of Nursing on 08/20/08 at 3:00PM, she was asked if a statement was obtained from the Nursing Supervisor, who was on duty at the time of the elopement, and she said "no." She stated that the Nursing Supervisor called her and she reported to the facility immediately, therefore a statement from the Nursing Supervisor #1 was not important. Upon inquiry regarding monitoring of the front door in the lobby, she stated that the security guard leaves at 7:00PM and that the Nursing Supervisor and nursing staff on the first floor are responsible for monitoring the cameras	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335079	A. BUILDING ______ B. WING ______	C 08/26/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD CREST CARE CENTER	**2316 BRUNER AVENUE BRONX, NY 10469**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 3 after 7:00PM. When she was asked about who was monitoring the cameras on 08/17/08 when the resident eloped from the facility at 7:35PM, she asserted that there was an emergency on the first floor and she did not know who was monitoring the cameras. Upon inquiry, she stated that there is no schedule for monitoring the cameras. Although, the DON stated that the Nursing Supervisor and first floor nursing staff are responsible for monitoring the cameras after the security guard's shift ends at 7:00PM, the facility's unsigned investigation summary did not address this issue and no corrective actions were put in place for this issue. The facility did not thoroughly investigate an incident of elopement. 415.4(b)(1)(ii)	F 225		
F 323 SS=K	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility failed to provide necessary supervision to a resident at risk for elopement. The facility failed to ensure facility exits and alarms were monitored by staff. The facility failed to implement policies and procedures related to	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335079	A. BUILDING ______ B. WING ______	C 08/26/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD CREST CARE CENTER	2316 BRUNER AVENUE BRONX, NY 10469

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F 323	Continued From page 4	F 323		

elopement to ensure that staff were trained regarding their responsibilities in elopement prevention. This deficient practice affected Resident # 1 who was able to elope from the facility undetected. In addition, it was determined that this deficient practice posed the potential for serious harm to 21 other residents residing at the facility identified as at risk for elopement.

This was evidenced in 1 of 10 sampled residents. (Resident #1).

This resulted in Immediate Jeopardy and Substandard Quality of Care to residents.

Complaint # NY00061483

The findings are:

Resident #1 was admitted to the facility on 5/10/07. His diagnoses include Dementia with Behavioral Disturbances, Psychosis, Hypertension, Emphysema/ Chronic Obstructive Pulmonary Disease. As per the Minimum Data Set 2.0 (MDS) dated 5/30/08 the resident has severely impaired cognitive skills for daily decision making, with short and long term memory problems. The MDS also notes that the resident has wandering behavior that occurred daily and was not easily altered.

A review of the facility's initial assessment tool titled "Wandering Residents" dated 5/10/07 revealed that Resident #1 was assessed upon admission and identified as a wandering resident. The Wandering Assessment documented that a wander guard was placed on the resident's right ankle on 5/10/07. The risk factors identified included: a history of wandering; direct

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335079	A. BUILDING ______ B. WING ______	C 08/26/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD CREST CARE CENTER	2316 BRUNER AVENUE BRONX, NY 10469

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 5	F 323		

observation of wandering by the staff; attempts to leave facility through entrances; attempts to enter stairwells; and impaired safety awareness.

The Comprehensive Care Plan (CCP) dated 6/3/08 documented that the resident is a potential risk for elopement secondary to a history of wandering. Interventions included placing a wander guard on the resident and monitoring the resident on and off the unit. Although the CCP did not document that the resident was on hourly monitoring, the hourly safety watch record documented that the resident was on hourly monitoring for the months of May, June July and August.

Review of the nurses notes revealed that on 5/22/08 the resident had threatened staff that if they did not let him out of the day room he would jump out of the window. Resident # 1 also verbalized that he wanted to go home. On 6/15/08, nurses notes documented that the resident continued to look for an exit. On 7/24/08, the nurses notes revealed that the resident had opened an exit door and went up the stairs toward the roof. On 7/25/08, the nurses notes documented that the resident attempted to go to the exit doors and elevators.

A review of the resident's CCP revealed that despite his numerous attempts to find exits and verbalization of wanting to go home the interventions remained the same.

A review of the facility's unsigned Investigation Summary report dated 08/18/08 revealed that Resident #1 was observed at 7:30PM interacting with visitors and other residents. He was noted missing at 7:55PM and code orange was initiated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335079	A. BUILDING ____ B. WING ____	C 08/26/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD CREST CARE CENTER	**2316 BRUNER AVENUE BRONX, NY 10469**

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F 323	Continued From page 6	F 323		

A search was initiated for the resident and the police were notified. Local hospitals were contacted as part of the external search. At 10:30PM the facility was informed that the resident had been brought to the Emergency Room by the EMS. The resident was returned to the facility unharmed at 2:00AM after he was evaluated in the Emergency Room. Review of the investigation did not reveal how the resident got out of the front door.

Review of the video surveillance on 8/19/08 at 12:30PM revealed that the resident exited the facility through the front door at approximately 7:35PM. The resident is seen going through the door without having to press on the push bar for 15 seconds, indicating his watch-mate did not function. No one was visible in the lobby or at the reception desk.

The facility's lobby is monitored by a receptionist/security guard from 8:00AM to 8:00PM on weekdays and 10:00AM to 7:00PM on weekends. The resident eloped from the facility after the receptionist/security guard left for the day, leaving the lobby unmonitored.

Interview with the Administrator and Director of Nursing on 8/19/08 at 12:30PM revealed that no receptionist/security guards are at the front desk after 7:00PM. They stated that they do not need a receptionist/security guard at the front desk at night because there is a Watch-Mate alarm system at the front door. Both stated that if a resident wearing a watch-mate entered a secured area in the lobby the door will automatically lock. The front door is equipped with a delayed egress locking system. If a resident pushes on the release bar for 15 seconds with 5 lbs of pressure,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335079	A. BUILDING ______ B. WING ______	C 08/26/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD CREST CARE CENTER	2316 BRUNER AVENUE BRONX, NY 10469

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 7	F 323		

Continued From page 7

the door will open and the resident can go out. An alarm will sound in the lobby. The Administrator stated that the residents "have Dementia, they don' t know how to push on the door for 15 seconds with 5 lbs" of pressure. Therefore, he does not need a 24 hour security guard in the lobby. He also stated that the Nursing Supervisor and the staff on the 1st floor Nursing unit on the evening shift are responsible for monitoring the cameras after 7:00PM.

The Watch-mate alarm was tested on 8/20/08 at 3:45PM. This alarm could be heard in the Nursing Supervisor's office, but was not audible on the first floor nursing unit. There is also a large dining room and two corridors prior to reaching the nursing unit. The alarm was not audible in these areas as well.

Observation of the front reception/security desk on 8/20/08 at 3:50PM revealed a monitor with 16 camera views including facility exits. The monitor is mounted on the wall to the left of the desk. In order for security/receptionist to view the monitor, it is necessary for them to turn around and look up at the screen. Monitoring screens are also located in the Nursing Supervisors' office, the first floor nursing station and the business office.

On 08/22/08 at 2:25PM, observation of the Nursing Supervisor's office was conducted in the presence of the DON. A monitor screen with 16 views was observed above the Nursing Supervisor's desk. To view the screen the Supervisor must turn her head and look up. When sitting at the desk and looking up at the monitor, several of the screens were noted to be dark. In a standing position all the views on the monitor were bright enough for identification.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335079	A. BUILDING ______ B. WING ______	C 08/26/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD CREST CARE CENTER	**2316 BRUNER AVENUE BRONX, NY 10469**

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F 323	Continued From page 8 The DON also sat in the chair and observed that some of the 16 views on the monitor were dark when sitting and bright when standing. RNS # 1 worked the 3PM to 11pm shift the night the resident eloped. On 08/22/08 at 1:10PM RNS #1 was interviewed regarding monitoring of the cameras. She asserted that at 7:20PM she was called to an emergency on the first floor nursing unit. When asked if she had delegated monitoring duty to any staff member, she replied, "no," everyone was busy with an emergency. She contends that when she arrived on the first floor nursing unit, which is located one door away from the nursing office on the first floor, no one was at the nursing station monitoring the cameras. She stated that while she was attending to the sick resident she was also "running back and forth from the resident's room to monitoring the cameras at the nursing station." When she was asked if she had received training on how to monitor the cameras, she said "no." In addition, she also stated that she is able to identify some of the camera locations if the screen is bright enough. The RNS stated that some of the screen is dark and that she is not able to see everything and that the monitor is positioned above her head and that she has to look up to see it. She also stated that there is no scheduling for monitoring the cameras. RNS # 1 stated that when she has to leave the office for any reason she has never delegated monitoring of the cameras to any of the 1st floor nursing staff. She stated there is a monitor is on the 1st floor nursing unit and staff knows that they should monitor the screen. On 8/22/08 at 4:30PM the L.P.N. who worked on the 1st floor the evening the resident eloped, was interviewed. She stated that she was attending to	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335079	A. BUILDING ______ B. WING ______	C 08/26/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD CREST CARE CENTER	2316 BRUNER AVENUE BRONX, NY 10469

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 9	F 323		

a resident who needed to be transferred to the hospital. She stated that she was in the resident ' s room and that no one was at the nurses' station. She also stated that she did not ask any staff to monitor the screen.

On 8/21/08 between 3:15PM. and 5:00PM three C.N.A's who worked on the 1st floor, the evening the resident eloped, were interviewed. All three C.N.A.'s stated that there was an emergency on the first floor with a sick resident and they were not monitoring the screen.

Interview with Registered Nurse Supervisor #2 on 8/22/08 at 4:15PM who also works on the evening shift stated that she was trained to monitor the screen and she delegates, to the nursing staff, the monitoring of the screen when she is out of the office.

During interviews on 8/22/08 on the 7-3 and 3-11 shift with 10 C.N.A.s and 4 Licensed Practical Nurses (L.P.N.) revealed that only one L.P.N. and two C.N.A's stated that they were asked to monitor the screen. Upon further inquiry, they all stated that they do not sit and constantly monitor the screen, they look at the screen in passing because they have work to do. They also stated that there is no scheduling for monitoring the screen.

Interviews with two security officers/receptionists on 8/22/08 at 4:30PM revealed that they were trained to monitor the screen but that they do not focus only on that. They also stated that they answer the phones, let people in and out of the facility and attend to visitors.

Review of the facility's Policy and Procedure titled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335079	A. BUILDING ______ B. WING ______	C 08/26/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD CREST CARE CENTER	2316 BRUNER AVENUE BRONX, NY 10469

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 10 "Resident at Risk for Elopement" with a revision date of 5/18/08 was reviewed. There is no mention of the monitoring of the camera screens in this policy. On 8/21/08 the DON was asked for the Policy and Procedure on Monitoring of the cameras and on Wander-guards. At this time the DON stated that there were no policies or procedures on monitoring of the cameras or on the Watch-mate system. On 8/26/08 at 12:08 PM the DON stated that she found the policies and procedures on the "Wander-guard". Two policies and procedures were provided. One policy was dated 4/04 and the revised Policy and Procedure was dated 8/08. It stated that when residents wearing the bracelet approach an alarmed door, it will immediately lock and sound an alarm at the nursing station showing a breached door. The staff will immediately respond to the area, re-direct the resident and disarm the lock. The policy does not mention monitoring the camera screens. The facility failed to ensure that residents at risk for elopement receive the supervision necessary to prevent elopement. 415.12(h)(2)	F 323		
F 490 SS=K	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: The Administrator failed to ensure that the facility	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335079	A. BUILDING ____ B. WING ____	C 08/26/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD CREST CARE CENTER	**2316 BRUNER AVENUE BRONX, NY 10469**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 11 operated in a manner in which the safety of all residents is maintained. Specifically, the Administrator failed to ensure that there were policies and procedures regarding the closed circuit monitors. The Administrator failed to ensure that staff implemented policies and procedures that ensure residents at risk for elopement receive necessary supervision. This was evidenced in 1 of 10 sampled residents. (Resident #1) It was also determined that this deficient practice posed the potential for serious harm to 21 other residents residing at the facility identified as at risk for elopement. This resulted in Immediate Jeopardy and Substandard Quality of Care to residents. Complaint # NY00061483 The findings are: The Administrator was interviewed on 8/19/08 at 12:30PM. He stated that the facility does not need a receptionist/security guard at the front desk at night because there is a Watch-Mate alarm system at the front door. If a resident wearing a watch-mate entered a secured area in the lobby the door will automatically lock. The front door is equipped with a delayed egress locking system. If a resident pushes on the release bar for 15 seconds with 5 lbs of pressure, the door will open and the resident can go out. An alarm will sound in the lobby. The Administrator stated that the residents "have Dementia, they don't know how to push on the door for 15 seconds with 5 lbs" of pressure. Therefore, he does not need a 24 hour security guard in the lobby.	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335079	A. BUILDING ______ B. WING ______	C 08/26/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD CREST CARE CENTER	2316 BRUNER AVENUE BRONX, NY 10469

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 12 Please see F 323 K 415.26	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335079	A. BUILDING ______ B. WING ______	R-C 09/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD CREST CARE CENTER	**2316 BRUNER AVENUE** **BRONX, NY 10469**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS	F 225		

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335079	A. BUILDING ______ B. WING ______	R-C **09/04/2008**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD CREST CARE CENTER	**2316 BRUNER AVENUE** **BRONX, NY 10469**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 1 by:	F 225		
{F 323} SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	{F 323}		
{F 490} SS=E	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	{F 490}		

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
335079	A. Building B. Wing	10/31/2008

Name of Facility	Street Address, City, State, Zip Code
GOLD CREST CARE CENTER	2316 BRUNER AVENUE BRONX, NY 10469

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4) LSC	09/18/2008	ID Prefix F0323 Reg. # 483.25(h) LSC	09/18/2008	ID Prefix F0490 Reg. # 483.75 LSC	09/18/2008
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:
8/26/2008

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**