

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/23/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/03/2006
NAME OF PROVIDER OR SUPPLIER KINGSBRIDGE HEIGHTS REHABILITA			STREET ADDRESS, CITY, STATE, ZIP CODE 3400 -26 CANNON PLACE BRONX, NY 10463		
(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 324 SS=D	<p>483.25(h)(2) ACCIDENTS</p> <p>The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility did not provide adequate supervision for a resident that was identified as a wanderer and at risk for elopement. The resident subsequently eloped from the facility on 4/21/06.</p> <p>This was evidenced in 1 of 5 sampled residents. (Resident #1)</p> <p>This resulted in no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.</p> <p>Complaint # NY00030382</p> <p>Findings are:</p> <p>Resident, age 74, was admitted to the facility on 11/9/02. Admitting diagnoses include Dementia with Psychosis, Alzheimer ' s Disease, Depression, and Hypertension. Minimum Data Set 2.0 dated 1/21/06 reveals that the resident has short-term and long-term memory deficits and has moderately impaired cognition.</p> <p>The facility Accident/Incident Report reveals that on 4/21/06 at 4:50PM, the resident was noted to be missing by the Certified Nursing Assistant (CNA)when she was getting residents ready for dinner. A facility-wide search was conducted and</p>	F 324			
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 324	<p>Continued From page 1</p> <p>the resident was not found. The Director of Nursing and the Staff Educator drove around the neighborhood and a report was filed with the NYPD.</p> <p>The 50th police precinct called the facility at approximately 8:00PM to inform them that the resident had been located at the apartment building where she formerly resided. The resident was returned to the facility at 8:30PM with no visible signs of injury. She was sent to the emergency room for evaluation and was returned to the facility at 4:00AM on 4/22/06.</p> <p>Care plan dated 10/25/05 for Behavioral Symptoms assesses the resident as at risk for elopement after attempts to leave the facility. Interventions include monitor behavior and record, encourage verbalization of feelings, interrupt resident ' s behavior promptly and divert attention, provide redirection by involving in activities, provide reality orientation, apply wanderguard and check placement every shift, hourly visual check, and provide a copy of resident ' s picture at the front desk.</p> <p>The Hourly Check Form reveals that the resident was visually checked every hour on the hour and the CNA who visually checked the resident was initialing the form. On 4/21/06 the resident was visually seen by the CNA at 4:00PM in the dayroom.</p> <p>Review of the facility surveillance videotape shows the resident walking out of the facility front door with another person at 4:09PM (It was determined that the other person was the son of another resident residing on the same unit) At the same time the resident is walking out, 2</p>	F 324			

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F 324	<p>Continued From page 2</p> <p>ambulance attendants are entering the facility with a resident in a stretcher.</p> <p>The Assistant Administrator was interviewed on 4/28/06 at 10:00AM He stated that after the review of the videotape and interviewing the staff at the reception desk that evening, it was determined that the receptionist assumed that the stretcher of the resident being wheeled in had set off the wanderguard alarm.</p> <p>The receptionist on duty on 4/21/06 during the 2:00PM -10:00PM was interviewed on the phone on 4/28/06 at 12:20PM. She stated that she is aware that it is her responsibility to respond to all alarms that sound. On the date/time that the resident left the facility, there were 2 employees at the reception desk but one had walked away as he was redirecting another wandering resident. She was alone at the desk when a new admission was being wheeled in on the stretcher. She stated that she assumed that the stretcher had set off the wanderguard alarm and she did not see Resident #1 exit the facility. The receptionist reset the wanderguard alarm, which is directly behind where she was sitting. She acknowledged that she made a mistake in assuming that the stretcher had caused the alarm to go off.</p> <p>The facility Interdisciplinary Policy and Procedure for the Wanderguard System reads that the receptionist ' s responsibility upon hearing the Wanderguard alarm sound, the receptionist should redirect resident and try to prevent him/her from leaving the building while immediately notifying staff members to escort resident back to the unit.</p> <p>The facility did not provide supervision to a</p>	F 324			

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F 324	Continued From page 3 resident identified as at risk for elopement who ultimately eloped. 415.12(h)(2)	F 324			

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 335028	(Y2) Multiple Construction A. Building _____ B. Wing _____	(Y3) Date of Revisit 5/31/2006
Name of Facility KINGSBRIDGE HEIGHTS REHABILITA		Street Address, City, State, Zip Code 3400 -26 CANNON PLACE BRONX, NY 10463

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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0324	Correction Completed 05/26/2006	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # 483.25(h)(2)		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	

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

Followup to Survey Completed on: 5/3/2006	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?
	YES NO