

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

PRINTED: 09/29/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335659	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/27/2008
NAME OF PROVIDER OR SUPPLIER TERRACE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2678 KINGSBRIDGE TERRACE 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 221 SS=D	<p>483.13(a) PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility did not ensure that residents were free from physical restraints without medical justification as evidenced by having a policy in place requiring all newly admitted residents to wear a wanderguard for a 7-day period without due cause. Additionally, a resident not identified as at risk for elopement was wearing a wanderguard for a total of 4 months after her admission date without being assessed for continuing use of the device.</p> <p>This was evidenced in 1 of 11 sampled residents (Resident #11) as well as all new admissions to the facility.</p> <p>This resulted in no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.</p> <p>Complaint # NY00057144</p> <p>The findings are:</p> <p>Resident #11, age 38, was admitted to the facility on 1/25/08 with diagnoses including Uncontrolled Hypertension, history of Substance Abuse, and Renal Insufficiency. She is also Legally Blind. The Minimum Data Set 2.0 dated 1/30/08 documents that the resident has short-term memory impairment, modified independence with cognitive</p>	F 221		

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 221	<p>Continued From page 1</p> <p>skills and no behavioral symptoms.</p> <p>Resident #11 is listed on the facility Wanderguard List dated 5/19/08. It states that the wanderguard on this resident is removed.</p> <p>Review of the electronic medical record did not reveal an elopement care plan or risk assessment identifying the resident as at risk for elopement. The IT Coordinator was asked to review the electronic medical record in search of these documents on 5/22/08 at 11:45AM. He stated that he could not locate them.</p> <p>The Assistant Administrator and the Assistant Director of Nursing were interviewed on 5/22/08 at 11:30AM. They were asked why Resident #11 appeared on the wanderguard list and they could not explain what the documentation on the list meant.</p> <p>The Assistant Administrator went on to explain that the facility Policy and Procedure states that all newly admitted residents are to wear a wanderguard for the first seven days at the facility. After this period, the resident is presented at a care plan meeting and it is determined whether the resident is at risk for elopement. If the resident is not considered a risk at this time, then the wanderguard is taken off. She can only assume that the resident's wanderguard device was taken off after the 7-day period and her name was still on the list. After clarifying with staff, she stated that the resident had been wearing a wanderguard and it had just been removed that morning. There was no evidence that the resident required a wanderguard. Review of the medical record did not reveal any documentation where the resident ever verbalized</p>	F 221			

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F 221	Continued From page 2 the desire to leave the facility or had ever attempted to leave the facility without a valid pass. Review of the facility Policy and Procedure titled "WanderGuards" with a revision date of 4/21/06 was reviewed. It states that upon initial assessment a wanderguard will be issued to residents during their first 7 days. After the 7 day assessment, residents without risk of elopement will have the wanderguard removed. The Assistant Administrator was asked if the policy applied to all residents regardless of cognitive status and she stated that it did. She continued to state that if an alert and oriented resident refuses to wear the wanderguard, it is not forced on them. Review of the wanderguard alarms reveal that there is one at the front door and one on the 1st floor exit that leads into an alley way. The Assistant Administrator confirmed that a resident with a wanderguard cannot exit to the exterior of the building without setting off a wanderguard alarm. The facility applied a physical restraint in the form of a wanderguard to all newly admitted residents without prior assessment thus prohibiting a resident that would not require a wanderguard from exiting the facility. Additionally, a resident without any risk for elopement was restrained with a wanderguard for a total of 4 months after admission.	F 221			
F 225	415.4(a)(2-7) 483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF	F 225			

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F 225 SS=G	Continued From page 3 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			

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F 225	<p>Continued From page 4</p> <p>by:</p> <p>Based on interview and record review, the facility did not thoroughly investigate an incident of elopement and did not develop a plan to prevent future elopements. The same resident eloped a second time and subsequently required hospitalization.</p> <p>This was evidenced in 1 of 11 sampled residents. (Resident #1)</p> <p>This resulted in actual harm that is not Immediate Jeopardy.</p> <p>Complaint #NY00057144</p> <p>The findings are:</p> <p>Resident #1 is a 48 year old male and has been at the facility since 12/4/07. His diagnoses include Cellulitis to the right leg, Hepatitis C, Hypertension, Esophageal Reflux, Asthma, Depression, and history of Intravenous Drug Use. The Minimum Data Set 2.0 dated 2/29/08 notes that the resident has no memory or cognitive impairments and no behavioral symptoms.</p> <p>A Comprehensive Care Plan was initiated on 12/13/07 identifying that the resident presents a history of illicit chemical and or alcohol use which has become problematic. Interventions include encouraging the resident in participating in discussions, discussing relapse prevention and triggers, and encouraging the resident to discuss feelings and misgivings.</p> <p>An unsigned facility Incident Investigation Report dated 3/4/08 was reviewed. It reveals that Resident #1 was discovered to have left the</p>	F 225			

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F 225	<p>Continued From page 5</p> <p>facility on 3/3/08 after morning report (approximately 7-7:30AM). Upon video tape review by facility staff, it was determined that the resident walked hastily through the front door when security was preoccupied at approximately 6:51AM. The resident returned to the facility after 7:00PM on the same date. He admitted to using heroin while out of the facility on "unauthorized leave of absence" as quoted by the facility on the investigation. The report indicates staff spoke to the resident about his drug use and he denied having a problem and declined detox/rehab. The report also states the "Resident was reminded of the pass policy."</p> <p>At this time, no reassessment was conducted to determine whether the resident was at risk for elopement with self injurious behavior. There were no interviews with staff members nor were there any interviews with security staff to determine how the resident was able to leave the facility via a secured door.</p> <p>An unsigned facility Incident Investigation Report dated 5/14/08 indicated that the resident eloped from the facility again on that date.</p> <p>The facility surveillance video was reviewed on 5/19/08 at 11:30AM. It reveals that the resident exited the facility through the front door of the facility at 8:24AM when the door was unlocked for an employee to exit. The video reveals one Security Guard seated at the desk and a second Security Guard walking in the Lobby area.</p> <p>Initial interviews with the security guards were not conducted by facility staff. A letter from the President of the security guard company dated 5/20/08 was given to the surveyor on 5/22/08. It</p>	F 225			

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F 225	<p>Continued From page 6</p> <p>states that he interviewed the security guards and they were unaware that the resident had left. The President of the security guard company disciplined the guards and inserviced the guards. The facility did not partake in the inservicing of the security guards.</p> <p>The Security Guard stationed behind the desk was interviewed on 5/22/08 at 5:00PM. He stated that he was working on a double shift and he remembers pressing the button to allow the nurse to exit, but does not recall seeing the resident in the lobby area or exiting. It was explained to him that the surveillance video shows the resident exiting immediately following the nurse but again, he stated that he did not see the resident or he would have stopped him.</p> <p>The second Security Guard was interviewed on 5/22/08 at 5:20PM. She stated that she was "in training" at the time. When asked how long she had been at the facility she stated at least 2 weeks. She was asked if residents are allowed to leave the facility and she stated only if they had a pass. She continued to state that she did not see the resident exiting the facility.</p> <p>The facility's Incident Investigation Report dated 5/14/08, does indicate the resident was missing since 8:24AM and therefore missed lunch and dinner. The investigation did not include any interviews with Dietary staff who would have been in the dining room serving the meals.</p> <p>The CNA (Certified Nurse Aide) assigned to the auxiliary dining room on 5/14/08 during the lunch meal was interviewed on 5/22/08 at 11:55AM. She stated that the resident has an assigned seat in the dining room and a tray is placed there for</p>	F 225			

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F 225	<p>Continued From page 7</p> <p>him. If a resident does not show up for a meal, the nursing unit is contacted. The nursing unit will then look for the resident and call back with instructions as to what to do with the tray (i.e. send it up to the unit or send back to the kitchen because the resident is out of the building). She further stated that there is no documentation as to whether a resident showed up or not but if a resident does not show up, she will called the unit and inform them. She cannot recall who she spoke to on 5/14/08 when Resident #1 did not show up for lunch, but states that she would have called the unit.</p> <p>The CNA assigned to the resident on the 3PM to 11PM shift was interviewed on 5/22/08 at 3:00PM and the LPN assigned to the nursing unit was interviewed on 5/22/08 at 2:49PM. Both stated that they did not receive a call from dietary stating that the resident was not present for the dinner meal.</p> <p>The facility's Incident Investigation Report does not determine whether phone calls were made from Dietary to the nursing units to inform them that the resident was not at the meals. There is no documentation that phone calls to the units are made.</p> <p>The CNA assigned to the resident on 5/14/08 from 7:00AM to 3:00PM was interviewed on 5/19/08 at 2:05PM. She stated that she remembers seeing the resident at 7:00AM when she came in. At 10:30AM she noticed that the resident's bed was not made and asked his roommate where the resident was and he responded by saying that he was in the smoke room. At 2:00PM, she still had not seen the resident so at 2:50PM she told the LPN. The CNA</p>	F 225			

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F 225	<p>Continued From page 8</p> <p>was asked if she searched for the resident and she stated that she did not.</p> <p>The LPN (Licensed Practical Nurse) on the resident's unit on 5/14/08 from 7:00AM to 3:00PM was interviewed on 5/23/08 at 11:40AM. He stated that he remembers seeing the resident in the morning around 7:15AM and then again between 8:00AM and 9:00AM when he gave him his medication. He does not recall seeing the resident again. He was told by a CNA near the end of the shift that she could not locate the resident, but he assumed he was in the smoking room which was his normal routine.</p> <p>The LPN on the resident's unit on 5/14/08 from 3:00PM to 11:00PM was interviewed on 5/22/08 at 2:49PM. She stated that she had received report from the day shift LPN that the resident was downstairs in the smoking room. She acknowledged that she did not look for the resident at the change of shift. She did not notice him missing until 9:00PM when a medication was due.</p> <p>As per the hospital record dated 5/15/08, the resident walked himself into the hospital on 5/15/08 with upper GI bleeding secondary to esophageal varices. A toxicology test was positive for cocaine and opiates.</p> <p>The facility did not thoroughly investigate the initial incident of elopement to determine how he was able to leave the facility undetected. The resident was able to elope again 2 months later, under the same circumstances, without being noticed. He was not noted to be missing for a total of twelve and a half hours and he was subsequently hospitalized.</p>	F 225			

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F 225	Continued From page 9	F 225			
F 323 SS=K	<p>415.4(b)(1)(ii) 483.25(h) ACCIDENTS AND SUPERVISION</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: The facility failed to supervise and monitor a resident who was able to elope from the facility for a twelve and half hour period without being noted as missing. The facility also failed to have a system in place to assess all residents for risk of elopement.</p> <p>This was evidenced in 1 of 11 sampled residents. (Resident #1) and potentially all residents admitted to the facility.</p> <p>This resulted Immediate Jeopardy and Substandard Quality of Care to Residents</p> <p>Complaint #NY00057144</p> <p>The findings are:</p> <p>Resident #1 is a 48 years old male and has been at the facility since 12/4/07. His diagnoses include Cellulitis to the right leg, Hepatitis C, Hypertension, Esophageal Reflux, Asthma, Depression, and history of Intravenous Drug Use. The Minimum Data Set 2.0 dated 2/29/08 notes</p>	F 323			

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F 323	<p>Continued From page 10</p> <p>that the resident has no memory or cognitive impairments and no behavioral symptoms.</p> <p>A Comprehensive Care Plan was initiated on 12/13/07 identifying that the resident presents with a history of illicit chemical and or alcohol use which has become problematic. Interventions included encouraging the resident to participate in discussions, discussing relapse prevention and triggers, and encouraging the resident to discuss feelings and misgivings.</p> <p>There is no assessment identifying the resident as at risk for elopement nor is there a care plan identifying him as at risk for leaving Against Medical Advice.</p> <p>Review of the Progress Notes reveals that on 2/21/08 and 2/27/08 the resident had verbalized to the Psychologist that he wished to have pass privileges. The resident stated that he needed a 5 hour pass and would decline a 30 minute or 1 hour pass if offered.</p> <p>At this time, no reassessment was done to determine whether the resident was at risk for elopement.</p> <p>The resident's Social Worker was interviewed on 5/19/08 at 10:50AM. He stated that the resident had not been given pass privileges due to his parole status. Numerous attempts had been made to contact the Parole Officer in order to set up guidelines to allow the resident to go out on pass. The Parole Officer did not respond. The Social Worker was again interviewed on 5/27/08 at 2:08PM and asked if he was aware of the resident's discussion with the Psychologist about refusing specific time-framed passes and he said</p>	F 323			

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F 323	<p>Continued From page 11 that he was not.</p> <p>Review of an unsigned Incident Investigation Report dated 3/4/08 reveals that on 3/3/08 the resident was discovered to have left the facility on 3/3/08 after morning report (approximately 7:00AM to 7:30AM). Upon video tape review, the resident was witnessed walking hastily through the door when security was preoccupied at approximately 6:51AM. The resident returned to the facility after 7:00PM. He admitted to using heroin while out of the facility on "unauthorized leave of absence" as quoted by the facility on the investigation. The report indicates staff spoke to the resident about his drug use and he denied having a problem and declined detox/rehab. The report also states the "Resident was reminded of the pass policy."</p> <p>At this time, no reassessment was conducted to determine whether the resident was at risk for elopement.</p> <p>As per an unsigned Incident Investigation Report dated 5/14/08, the resident eloped from the facility again on that same date.</p> <p>The facility surveillance video was reviewed on 5/19/08 at 11:30AM. It reveals that the resident exited the facility through the front door of the facility at 8:24AM when the door was unlocked for an employee to exit. The video reveals one Security Guard seated at the desk and a second Security Guard walking in the Lobby area.</p> <p>The resident was not accounted for at lunch and dinner and missed 1:00PM and 5:00PM medications and staff failed to initiate a search.</p>	F 323			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335659	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/27/2008
NAME OF PROVIDER OR SUPPLIER TERRACE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2678 KINGSBRIDGE TERRACE 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 323	<p>Continued From page 12</p> <p>The Certified Nursing Assistant (CNA) assigned to the resident on 5/14/08 from 7:00AM to 3:00PM was interviewed on 5/19/08 at 2:05PM. She stated that she remembers seeing the resident at 7:00AM when she came in. At 10:30AM she noticed that the resident's bed was not made and asked his roommate where the resident was and he responded by saying that he was in the smoke room. At 2:00PM, she still had not seen the resident, so at 2:50PM she told the Licensed Practical Nurse (LPN). The CNA stated that she never attempted to locate the resident herself.</p> <p>The LPN on the resident's unit on 5/14/08 from 7:00AM to 3:00PM was interviewed on 5/23/08 at 11:40AM. He stated that he remembers seeing the resident in the morning around 7:15AM and then again between 8:00AM and 9:00AM when he gave him his medication. He does not recall seeing the resident again. He was told by the CNA near the end of the shift that she could not locate the resident, but he assumed he was in the smoking room which was his normal routine.</p> <p>The CNA assigned to the auxiliary dining room on 5/14/08 during the lunch meal was interviewed on 5/22/08 at 11:55AM. She stated that the resident has an assigned seat in the dining room and a tray is placed there for him. If a resident does not show up for a meal, the nursing unit is contacted. The nursing unit will then look for the resident and call back with instructions as to what to do with the tray (i.e. send it up to the unit or send back to the kitchen because the resident is out of the building). She further stated that there is no documentation as to whether a resident showed up or not but if a resident does not show up, she will called the unit and inform them. She cannot</p>	F 323			

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F 323	<p>Continued From page 13</p> <p>recall who she spoke to on 5/14/08 when Resident #1 did not show up for lunch, but states that she would have called the unit.</p> <p>There is no documentation that the nursing unit was called to be informed that the resident did not show up for the lunch meal.</p> <p>The LPN on the resident's unit on 5/14/08 from 3:00PM to 11:00PM was interviewed on 5/22/08 at 2:49PM. She stated that she had received report from the day shift LPN that the resident was downstairs in the smoking room. She acknowledged that she did not look for the resident at the change of shift and it is her responsibility to account for each resident. She did not notice him missing until 9:00PM when a medication was due.</p> <p>The CNA assigned to the resident on the 3PM to 11PM shift was interviewed on 5/22/08 at 3:00PM. She stated that she was told by the day CNA that the resident was probably in the smoking room and she acknowledged that she did not look for the resident. She was asked if she should have physically looked for the resident at the change of shift and she stated "Yes. I suppose so."</p> <p>Both the CNA and the LPN on the 3:00PM to 11:00PM shift stated that they did not receive a call from dietary stating that the resident was not present for the dinner meal.</p> <p>There is no documentation that the nursing unit was called and informed that the resident did not show up for the dinner meal.</p> <p>Review of the Medical Administration Record for</p>	F 323			

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F 323	<p>Continued From page 14</p> <p>the resident reveals that the resident did not receive Atrovent inhaler 2 puffs at 1:00PM and 5:00PM and no attempt was made to locate the resident for the administration of the medication.</p> <p>A facility Policy and Procedure titled "Criteria For Risk Assessment 'Wandering' or 'Elopement' and the Care Plan Process" was given to the surveyor on 5/19/08. There is no initial date or revision date posted on it. The policy states that residents will have a Risk Assessment form completed to ascertain the risk factors for wandering and/or elopement. The form will be completed on admission, episodically, quarterly and whenever a significant change occurs.</p> <p>A review of 11 random sampled medical records revealed that no elopement risk assessments were conducted.</p> <p>The Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Quality Assurance Manager, and Assistant Administrator were interviewed as a group on 5/22/08 at 1:06PM. They were asked how residents are assessed for elopement during their length of stay at the facility. There was no response from any of the administrative personnel. They were asked if they were aware of the policy identifying a risk assessment tool. None were aware of this policy.</p> <p>The Assistant Administrator stated that residents are assessed upon admission and they are required to wear a wanderguard for the first 7 days at the facility. After this period, the care plan team will meet and discuss the resident's status. If the resident is deemed at risk for elopement, the wanderguard stays on and a care plan is initiated.</p>	F 323			

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F 323	Continued From page 15	F 323			
F 490 SS=K	<p>Review of the facility Policy and Procedure titled "WanderGuards" with a revision date of 4/21/06 was reviewed. It states that upon initial assessment a wanderguard will be issued to residents during their first 7 days if assessment. After the 7 day assessment, residents without risk of elopement will have the wanderguard removed.</p> <p>The facility failed assess residents for the risk of elopement after the initial 7 day period upon admission.</p> <p>415.12(h)(1) 483.75 ADMINISTRATION</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on Interview and record review the Administrator failed to ensure that the facility operated in a manner in which its policies are initiated, followed, and evaluated for effectiveness. The Administrator failed to ensure that residents are assessed and monitored for prevention of elopement. The Administrator did not ensure that staff was aware of the policies and procedures.</p> <p>This was evidenced in 1 of 11 sampled residents. (Resident #1) and posed potential harm to all residents at the facility.</p>	F 490			

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F 490	Continued From page 16 This resulted in Immediate Jeopardy and Substandard Quality of Care to residents. Complaint ID # NY00057144 The findings are: See F 323 K The Administrator was interviewed on 5/27/08 at 2:19PM. He stated that it is his responsibility for the implementation of all policies at the facility. He is now aware of the lack of policies pertaining to elopement assessment. The Administrator stated that he gave the Nursing Department administration guidelines to implement elopement assessments a while back but he failed to follow up on it to ensure that it was implemented.	F 490			
F 501 SS=K	415.26 483.75(i) MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Medical Director failed to be involved in the development, review, and/or implementation of resident care policies that address resident behaviors, specifically the assessment of residents to	F 501			

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F 501	<p>Continued From page 17</p> <p>determine if they were at risk for elopement and the development of care plans.</p> <p>This was evidenced in 1 of 11 sampled residents. (Resident #1) and posed potential harm to all residents at the facility.</p> <p>This resulted in Immediate Jeopardy and Substandard Quality of Care to residents.</p> <p>Complaint ID # NY00057144</p> <p>The findings are:</p> <p>See F 323 K</p> <p>The Assistant Medical Director was interviewed on 5/27/08 at 1:00 PM. He stated the Medical Director's office oversees any medical issues with the residents. They have medical staff meetings and discuss residents but they do not partake in policy decision making.</p> <p>The Assistant Medical Director continued to state that he will only attend the care plan meeting if there is a medical reason such as a change in medications or if the social worker has cleared a resident for pass privileges and a medical clearance is needed otherwise, he will not attend.</p> <p>He was asked if he was aware of the lack of policies and procedures regarding elopement behavior and assessment of such and he stated that he was not.</p> <p>415.15(a)</p>	F 501			

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NAME OF PROVIDER OR SUPPLIER TERRACE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2678 KINGSBRIDGE TERRACE BRONX, NY 10463		
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{F 221} SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.	{F 221}			
{F 225} SS=G	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	{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.

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{F 225}	Continued From page 1 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.	{F 225}			
{F 323} SS=E	This REQUIREMENT is not met as evidenced by: 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.	{F 323}			
{F 490} SS=E	This REQUIREMENT is not met as evidenced by: 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.	{F 490}			
{F 501} SS=E	This REQUIREMENT is not met as evidenced by: 483.75(i) MEDICAL DIRECTOR The facility must designate a physician to serve as medical director.	{F 501}			

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{F 501}	Continued From page 2 The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by:	{F 501}		

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 335659	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 7/15/2008
Name of Facility TERRACE HEALTH CARE CENTER	Street Address, City, State, Zip Code 2678 KINGSBRIDGE TERRACE 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 <u>F0221</u> Reg. # <u>483.13(a)</u> LSC _____	Correction Completed <u>07/10/2008</u>	ID Prefix <u>F0225</u> Reg. # <u>483.13(c)(1)(ii)-(iii), (c)(2) - (4)</u> LSC _____	Correction Completed <u>07/10/2008</u>	ID Prefix <u>F0323</u> Reg. # <u>483.25(h)</u> LSC _____	Correction Completed <u>07/10/2008</u>
ID Prefix <u>F0490</u> Reg. # <u>483.75</u> LSC _____	Correction Completed <u>07/10/2008</u>	ID Prefix <u>F0501</u> Reg. # <u>483.75(i)</u> LSC _____	Correction Completed <u>07/10/2008</u>	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
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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: 5/27/2008	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="display: inline-table; margin-left: 20px;"> <tr> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> </tr> </table>	YES	NO
YES	NO		