

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

PRINTED: 11/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335523	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/06/2008
NAME OF PROVIDER OR SUPPLIER NORWEGIAN CHRISTIAN HOME & HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1270 67TH STREET BROOKLYN, NY 11219		
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F 323 SS=K	<p>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: Based on observations, interviews and record review the facility failed to provide supervision to residents at risk for elopement. The facility failed to ensure that each resident received adequate supervision, for 3 of 8 resident's sampled for elopement. (Resident # 1, # 2 and # 3). This resulted in Resident # 1 eloping from the facility undetected through a door that failed to alarm and staff were unaware the resident was missing.</p> <p>A. The facility failed to ensure that front desk personnel and security officers responsible for monitoring the door access system were trained regarding the purpose, function and operation of the system.</p> <p>B. The facility failed to implement policies and procedures to ensure that facility staff provide supervision to residents who were identified as being at risk for elopement. Facility staff did not implement care plan interventions of 15-minute visual checks.</p> <p>This deficient practice affected Resident # 1 and had the potential to affect 11 other residents identified as at risk for elopement resulting in a pattern. This resulted in no actual harm with the potential for serious harm that was Immediate</p>	F 323			

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 323	<p>Continued From page 1</p> <p>Jeopardy and Substandard Quality of Care. It was determined that the facility implemented appropriate measure to remove the Immediate Jeopardy as of 8/5/08 prior to the survey exit.</p> <p>Complaint ID # NY00060911</p> <p>1. A. Resident # 1 is a 93-year-old male admitted on 4/15/05. His diagnoses include Dementia and Benign Prostatic Hypertrophy (BPH). The Minimum Data Set 2.0 (MDS) dated 4/14/08 noted that the resident has moderately impaired cognition with long and short-term memory problems. The MDS also noted that the resident had wandering behavior that was not easily altered.</p> <p>An updated Safety Comprehensive Care Plan (CCP) dated 7/10/08 revealed that the resident wanders on the unit into other residents' rooms and attempts to elope. His wandering is related to Dementia, cognitive impairment, short-term memory loss and judgment deficit. Interventions included providing ID bands/pictures at security post, 15 minute visual checks and a wander guard to the resident's left ankle.</p> <p>The facility's Occurrence/Investigative report noted that on 8/3/08, staff last saw the resident at approximately 9:25AM walking towards his room. According to a Certified Nursing Assistant (CNA) she noted that the resident was missing at 10:30AM when she began her assigned TV room monitoring. When the unit was searched, the resident was not found. At 10:40AM the supervisor was notified and "Code E" for a missing resident was announced. A complete search of the building and surrounding neighborhood were initiated and the police were</p>	F 323		

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F 323	<p>Continued From page 2</p> <p>notified. At 1:00PM the police notified the facility that the resident was found sitting on a stoop in the neighborhood and was taken to the hospital. The resident was observed by facility staff in the emergency room and noted to be wearing his wander guard on his right ankle. However, the resident was not wearing his ID bracelet. The resident was returned to the facility uninjured at 3:00PM the same day.</p> <p>According to the Investigative report completed by the Director of Nursing (DON), the resident left the unit via an alarmed door that connects the facility to an adjacent assisted living facility. From there the resident walked down two flights of stairs and exited the adjacent facility through an unalarmed door behind the kitchen. The resident was able to cross over to the adjacent facility undetected because the door alarm was not working due to two (2) short power outages that occurred on the day before the elopement. Video surveillance revealed that the resident walked away from staff and towards his room at 9:23AM. At 9:24AM the resident is seen on the video exiting from the adjacent facility. According to the staff interviewed, no staff members could account for the resident's whereabouts between 9:30AM and 10:30AM. The resident had been care planned to receive 15-minute visual checks that were not completed. The report noted that "the root cause analysis revealed multi-system failure in monitoring resident on unit according to plan of care". It further notes that the "security guard at desk failed to monitor camera and alarm panel and report negative findings to Supervisor or Director of Maintenance in a timely manner".</p> <p>The Front Desk Receptionist (FDR # 1) was interviewed on 8/5/08 at 11:07AM. He worked on</p>	F 323			

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F 323	<p>Continued From page 3</p> <p>8/2/08 and 8/3/08. He stated that there were two power outages on 8/2/08 due to bad weather. The power was out for no more than a few seconds. He was not at the desk when it occurred, however his co-worker (FDR # 2) was there and she called the Director of Maintenance. The fire department also responded and all systems were cleared. FDR # 1 stated that he did observe that the door access monitor was off and tried to restart it but was unsuccessful. When asked about the purpose of the monitor he stated that he knew it was there but did not know what it was for. He was unaware that the system monitored when alarmed doors were accessed and did not know to report that it was not working. On the day of the elopement, FDR # 1 stated that he did not see the resident exiting the facility on video surveillance, and no wander guard alarms were triggered.</p> <p>FDR #2 was interviewed on 8/4/08 at 2:15PM. She stated that she reported the power outages to the Director of Maintenance on 8/2/08. FDR # 2 stated that all systems were functioning after the power outages and she was not aware that the stairwell door alarms were not functioning. When asked about the door access computer monitor, she stated that after the power outages occurred she did not notice whether the monitor was off or on. She further stated that she knew the monitor had to be on. FDR # 2 stated she was not trained on what the system was used for. She became aware that the door alarms were not working after the resident eloped.</p> <p>The Director of Maintenance was interviewed on 8/4/08 at 11:55AM. The Director of Maintenance stated that he was made aware of the power outages on 8/2/08 via telephone. He was told by</p>	F 323			

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F 323	<p>Continued From page 4</p> <p>the receptionist that the power went out very briefly but all systems were still functioning. He stated he was not told that the door access computer system was not functioning. He added that he was away for the weekend when the power outages occurred and could not come to the facility. The Director of Maintenance stated the Administrator told him on 8/3/08 at 5:00PM that the alarmed doors malfunctioned. This was after Resident # 1 had eloped from the facility. The Director of Maintenance arrived at the facility after 10:00PM on 8/3/08 and noticed that the door access computer system at the front desk was off and could not be powered on. He explained that the systems at the front desk monitor the wander guard, video surveillance, fire alarms and door access. The door access monitor records when alarmed doors are accessed. If a door is accessed without a code it is displayed with red lettering on the monitor. The Director of Maintenance stated that front desk personnel and security uses this system to monitor the stairwell exit doors for breaches or forced entry. The computer monitor screen should be on at all times. He went to the fuse box in another location and found that a fuse had blown, which resulted in the malfunction of the door alarms.</p> <p>In a subsequent interview with the Director of Maintenance on 8/5/08 at 10:20AM he was asked about the training of front desk and security personnel. He stated that he gives a verbal training to his staff regarding all systems including the door access computer. The Director of Maintenance stated the training is not documented and may not have been given to 100 percent of his staff.</p> <p>On 8/4/08 and 8/5/08 interviews were conducted</p>	F 323			

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F 323	<p>Continued From page 5</p> <p>with 2 security guards and 3 front desk receptionists regarding their knowledge of the door access computer system at the front desk. One of the two security guards (SG # 1) did not have knowledge of the computer that monitored the door access. The one security guard (SG # 2) that was knowledgeable of the computer was not trained on the system but knew about it by his own observations. Two of the 3 receptionists did not have knowledge of the function and the purpose of the door access computer.</p> <p>The Security Guard (SG # 1) was interviewed on 8/5/08 at 11:25AM. He stated that he worked on 8/2/08 starting at 4:00PM. He made building rounds before 7:00PM, and noted that the alarmed doors were not functioning. He told the other security guard on duty (SG # 2) about the doors, and SG # 2 stated that the alarm doors were not working because of the power outages. SG # 1 stated that after making the building rounds, he went on his break, however he had to leave the facility at 8:00PM due to a family emergency.</p> <p>SG # 2 was interviewed on 8/5/08 at 2:20PM. SG # 2 worked on 8/2/08 from 4:00PM through 12:00AM. He was aware of the power outages that occurred during the day on 8/2/08. SG # 2 stated that during his tour he was not told that the alarmed doors were not functioning. He was also asked if he attempted to get a replacement for SG # 1 whom left the tour early. SG # 2 stated he did not think to do that.</p> <p>The Director of Maintenance on 8/5/08 at 10:20AM was interviewed about the procedure for routine checking of the alarmed doors for functioning. He stated that the security officer</p>	F 323		

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F 323	<p>Continued From page 6</p> <p>that works from 4:00PM to 12:00AM makes building rounds daily to check doors and to secure the facility. The rounds are documented in the log book. The Director of Maintenance stated that there is no documentation noting that alarmed doors were checked on the day the power outages occurred.</p> <p>A review of the log book entries for 7/31/08 through 8/4/08 revealed no documentation noting that the armed door were checked for functioning.</p> <p>In a subsequent interview with the Director of Maintenance on 8/5/08 at 3:15PM, he was asked about the procedure for replacing staff that leave before their shift is over. The Director of Maintenance stated that at the time SG # 1 left his tour, he was not notified. He was unable to verbalize procedures for replacing staff that leave before their tour is over.</p> <p>B. A review of Resident # 1's 15-minute visual check sheets for July and August 2008 revealed missing signatures on 4 days in July and on 3 days in August, including the day of the elopement (8/3/08). On 8/3/08, there were no 15-minute visual checks documented for the resident since 5:45AM.</p> <p>Resident # 1's Assigned CNA (CNA # 1) was interviewed on 8/4/08 at 2:45PM. She stated she took Resident # 1 to the TV room at 8:30AM so that he could be monitored. She admitted that on 8/3/08 she did not complete the 15-minute visual check sheet for the resident between 6:00AM and 8:30AM.</p> <p>CNA # 2 was interviewed on 8/4/08 at 3:15PM. She stated that she monitored the TV room at</p>	F 323			

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F 323	<p>Continued From page 7</p> <p>8:30AM through 9:00AM on 8/3/08. Resident # 1 was in the TV room during her monitoring time however she did not document it on the 15-minute visual check sheet.</p> <p>CNA # 3 was interviewed on 8/4/08 at 1:40PM. She stated that when she began to monitor the TV room at 9:00AM, the resident was there. When CNA # 3 left the TV room at 9:30AM the resident was in the TV room. CNA # 3 stated that she did not document 15-minute visual checks for the resident although she was required to do so.</p> <p>CNA # 4 was interviewed on 8/4/08 at 4:10PM. At 9:30AM, it was her turn to monitor the TV room. She asked CNA # 3 if the resident was still in the lounge, and CNA # 3 gestured with her hand that he went in the direction of his room. CNA # 4 stated that she did not check the whereabouts of the resident during her monitoring of the TV room.</p> <p>CNA # 5 was interviewed on 8/5/08 at 9:00AM. She stated that she was assigned to monitor the TV room at 10:00AM and arrived at 10:15AM. She began checking for all the residents that were supposed to be in the TV room and realized that Resident # 1 was not there. At the same time, CNA # 6 arrived at the TV room to begin her monitoring at 10:30AM and was also looking for the resident. She told CNA # 5 that the resident was not in his room. At this time they started to look for the resident on the unit but hey did not find him. After 10 minutes the supervisor was notified.</p> <p>The Director of Nursing (DON) was interviewed on 8/4/08 at 11:11AM about the procedure for completing 15-minute visual checks. The DON</p>	F 323			

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F 323	<p>Continued From page 8</p> <p>stated that CNAs take turns monitoring the TV room. The CNA that is monitoring the TV room is responsible for completing the 15-minute visual checks for all residents that require it. Prior to the time that the TV room monitoring begins, the assigned CNA is responsible for the 15-minute visuals. The DON stated that when she reviewed the 15-minute visual check sheets for Resident # 1 post incident, she noticed a "compliance issue" with documenting the 15-minute visual checks.</p> <p>The four (4) CNAs that were responsible for monitoring the TV room at different intervals between 8:30AM and 10:30AM on 8/3/08 were interviewed. They all stated that they did not document 15-minute visual checks for Resident # 1, as they were required to do during their TV room monitoring times.</p> <p>The Registered Nurse Supervisor (RNS # 2) was interviewed on 8/5/08 at 8:43PM. She stated that on 8/3/08 at 10:40AM the unit nurse (LPN) informed the RNS # 2 that the resident could not be found on the unit and Code E was called. A search was initiated and the police were contacted. RNS # 2 stated that when the police arrived, she escorted them through the building. The officers wanted to go to the adjacent facility so she escorted them to the alarmed door (the alarmed door requires an access code for entry). When RNS # 2 entered in the access code, lights on the code keypad started to flash which was unusual. When she opened the door she heard a "feeble" sound that was barely audible. She stated this was also unusual because there is usually a loud sound that is heard when the door is opened. RNS # 2 reported this to the receptionist.</p>	F 323			

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F 323	<p>Continued From page 9</p> <p>2. Resident # 2 is a 79-year old male admitted to the facility on 5/8/08 with diagnoses including History of Alcohol Abuse, Anemia and Hypovolemia. As per the Minimum Data Set dated 5/29/08 the resident's short tem and long term memory are both impaired and his decision-making abiltiy is moderately impaired.</p> <p>As per the resident's Safety Care Plan updated 7/16/08 the resident displays wandering behavior and has a histoy of refusing to wear a wanderguard. The goals of the care plan are that the resident will wander safely and not leave the facility without an escort. The interventions included safety checks every 15-minutes.</p> <p>Resident # 3 is an 84-year-old woman admitted to the facility on 11/29/07 with diagnoses including Alzheimer's Dementia, Chronic Obstructive Pulmonary Disease, and Hypertension. As per the Minimum Data Set dated 4/11/08 the resident's short-term and long-term memory are both impaired and her decision-making ability is moderately impaired.</p> <p>According to the resident's Safety Care Plan updated on 7/24/08 the resident displays wandering behavior and attempted to leave the unit unescorted. The goals of the care plan are the resident will wander safely and will not leave the facility without an escort. The interventions included visual checks every 15-minutes.</p> <p>A review of the 15-minute visual check sheets for two residents (Resident # 2 and # 3) revealed missing signatures on 3 days in July and on 2 days in August for Resident # 2, and on 3 days in August for Resident # 3.</p>	F 323			

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F 323	<p>Continued From page 10</p> <p>The Assistant Director of Nursing was interviewed on 8/5/08 at 2:05PM. She was asked about the policy regarding compliance with the requirement that CNAs document 15-minute checks. She stated the Registered Nurse Supervisors are generally required to check all CNA forms for compliance, each month before they are filed. However, they were in-serviced just last week, and they were instructed to check all CNA forms weekly for compliance, so that staff could be disciplined for non-compliance in a timely fashion.</p> <p>Two (2) Registered Nurse Supervisors were interviewed on 8/4/08 and 8/5/08. They were asked about checking for compliance of CNA documentation of 15-minute checks. They did not give consistent responses regarding when or how often they checked for compliance. RNS # 1 stated that she checked the 15-minute visual check sheet last Thursday (7/31/08) but only viewed that day's entries. RNS # 2 stated that she checks daily on a spot check basis.</p> <p>It was determined that the facility removed the Immediate Jeopardy on 8/5/08 when corrective measures were initiated following the incident. The measures included:</p> <p>Resident # 1 was placed on and maintained on one to one monitoring on 8/3/08 when he returned to the facility.</p> <p>On 8/4/08 the external door that the resident exited from was equipped with a local alarm that sounds when opened and requires a key to shut off the alarm. The alarmed door that connected the two facilities was repaired.</p> <p>Beginning 8/4/08 the facility provided in-service to</p>	F 323			

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(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 11 all staff regarding elopement and completion and documentation of visual checks. The in-service also included training on the facility's electronic monitoring systems including the door access computer. All staff were in-serviced including nursing, front desk receptionist and security guards. Documentation was provided to the surveyor including signatures and lesson plans.	F 323			
F 490 SS=K	415.12(h)(1)(2) 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: Based on observations, interviews and record review the Administrator failed to ensure that the facility operates in a manner in which residents at risk for elopement receive supervision to prevent elopement. The Administrator also failed to ensure that front desk personnel and security officers responsible for monitoring the door access system were trained regarding the operation of the system. This was evidenced in 3 of 8 sampled residents. (Residents # 1, # 2 and # 3). This deficient practice affected Resident # 1 and had the the potential to affect 11 other residents identified as at risk for elopement. This resulted in no actual harm with the potential for serious harm that was Immediate Jeopardy and Substandard Quality of Care. It was determined	F 490			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335523	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/06/2008
NAME OF PROVIDER OR SUPPLIER NORWEGIAN CHRISTIAN HOME & HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1270 67TH STREET BROOKLYN, NY 11219		
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F 490	<p>Continued From page 12</p> <p>that the facility implemented appropriate measure to remove the Immediate Jeopardy as of 8/5/08 prior to the survey exit.</p> <p>This resulted in Immediate Jeopardy (Removed) and Substandard Quality of Care for residents.</p> <p>Complaint ID # NY00060911</p> <p>The Administrator was interviewed on 8/5/08 at 2:42PM. He was asked about the facility's policy and procedure regarding the training of front desk and security personnel. He stated that the Director of Maintenance is responsible for the training of front desk and security personnel. The Administrator had no documentation pertaining to the training of front desk and security personnel and referred the surveyor to the Director of Maintenance for further information.</p> <p>The Director of Maintenance was interviewed 8/5/08 at 10:20AM. He was asked about the training of front desk and security personnel. He stated that he gives a verbal training to his staff regarding all systems including the door access computer. The Director of Maintenance stated the training is not documented and may not have been given to 100 percent of his staff.</p> <p>See F 323 K</p> <p>415.26</p>	F 490			

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 335523	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 9/12/2008
Name of Facility NORWEGIAN CHRISTIAN HOME & HEALTH CENTER		Street Address, City, State, Zip Code 1270 67TH STREET BROOKLYN, NY 11219

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 F0323	Correction Completed 09/05/2008	ID Prefix F0490	Correction Completed 09/05/2008	ID Prefix _____	Correction Completed
Reg. # 483.25(h)		Reg. # 483.75		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: 8/6/2008	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="float: right; margin-left: 20px;"> <tr> <td>YES</td> <td>NO</td> </tr> </table>	YES	NO
YES	NO		