STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335011	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Patrick's Home	66 Van Cortlandt, Park South Bronx, NY 10463

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews, and interviews during survey, the facility failed to ensure that a resident was free from physical abuse. This was evident for one (Resident #1) of four residents reviewed for abuse. Specifically, on 05/27/2025 at 10:10 PM, Resident #1 reported that Certified Nursing Assistant #1 hit them on their nose and grabbed their hand. Registered Nurse Supervisor #1 assessed Resident #1 and noted Resident #1 had a 2-centimeter skin tear on the left arm and a swollen nose bridge. Resident #1 received Tylenol 650 milligrams for pain and was transferred to the hospital on [DATE] at 12:00 AM for evaluation. Resident #1 did not return to the facility. This resulted in actual harm to Resident #1 that was not Immediate Jeopardy.The findings are: The facility policy and procedure titled Abuse Policy with a review date 06/01/2024 documented the facility prohibits the mistreatment, neglect, and abuse of residents/patients and misappropriation of resident/patient property by anyone including but not limited to staff, family, friends and residents of the facility. The facility prohibits any exploitation of the mentally and physically disabled resident in the facility. The facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident/patient abuse, neglect, mistreatment, and/or misappropriation of property. Resident #1 was admitted to the facility with diagnoses of spinal stenosis (narrowing of the spaces within the spine), depression and dementia (decline in cognitive function). The Minimum Data Set (a resident assessment tool) dated 04/11/2025, documented Resident #1 had moderate impairment in cognition. Resident #1 required one person assistance with bed mobility and toileting hygiene. A nursing progress notes by Licensed Practical Nurse #1 dated 05/27/2025 at 10:38 PM, documented Resident #1 sustained a skin tear to the left arm when Certified Nursing Assistant #1 was trying to provide care to them. Certified Nursing Assistant #1 called Licensed Practical Nurse #1 immediately. Licensed Practical Nurse #1 cleaned the wound to stop bleeding and applied a dressing. Resident #1 complained of generalized pain of 4/10 on pain scale. Pain medication was administered as per physician's order. A nursing progress note by Registered Nurse Supervisor #1 dated 05/28/2025 at 12:08 AM, documented Licensed Practical Nurse #1 reported that Resident #1 stated Certified Nursing Assistant #1 hit and scratched their arm. Resident #1 was assessed and observed to have a 2-centimeter skin tear at the area of a purpura (purple-colored spots or patches on the skin caused by blood that just is under the skin surface) on their left arm and about 1-centimeter swelling over the nose bridge with no skin break. Resident #1 stated they (Certified Nursing Assistant #1) hit them on the nose and grabbed their hand. Resident #1 was immediately assigned to another staff and placed on one-to-one supervision. Nurse Practitioner #1 and the Director of Nursing and family were notified. Nurse Practitioner #1 ordered to transfer Resident #1 to the hospital for further evaluation. Resident #1 left the facility at 12:00 AM on 05/28/2025. A medical progress note by the on-call Nurse Practitioner #1 dated 05/28/2025 at 1:52 AM, documented Registered Nurse Supervisor #1 initiated a telehealth call and stated Resident #1 reported Certified Nursing Assistant #1 hit them on the bridge of their nose and scratched their left arm. A physical examination assisted by Registered Nurse Supervisor #1, revealed left arm skin abrasion and swelling to the bridge of Resident #1's nose, (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Tylenol 650 milligram medication ordered and to transfer Resident #1 to the hospital for further evaluation. The facility's Investigation form dated 06/01/2025 documented on 05/27/2025 at approximately 10:10 PM, Certified Nursing Assistant #1 stated they answered Resident #1's call bell and Resident #1 asked to be changed. Certified Nursing Assistant #1 stated they turned Resident #1 on their right side and while they were cleaning, Resident #1 turned on their back and started to hit and kick them. Resident #1 suddenly sat up in bed and continued to swing and hit them. Certified Nursing Assistant #1 then held Resident #1's arms to prevent injury to both. Certified Nursing Assistant #1 was able to demonstrate how they held Resident #1 and the way Resident #1 moved their arms in all directions. Certified Nursing Assistant #1 let them go and saw the skin tear. Resident #1 had a plastic identification band and the assigned Certified Nursing Assistant #1 had on a silver metal bracelet. Registered Nurse Supervisor #1 was notified and assessed Resident #1. Resident #1 reported that Certified Nursing Assistant #1 hit them and scratched their arm. Nurse Practitioner #1, Director of Nursing, Administrator and Resident Representative were notified. Resident #1 was sent to the hospital for further evaluation. The Resident Representative stated that Resident #1 had a linear fracture on their nose and was admitted to the hospital. Interview with other staff members stated Resident #1 mentioned that Certified Nursing Assistant #1 did not hang their clothes but folded them and put their knitting items on the low shelf instead of the high shelf drawer. Certified Nursing Assistant #1 was suspended pending investigation. Local police arrived on 05/28/2025 at 2:05 PM and did not give a report. The incident was not witnessed and Resident #1's roommate did not hear any noise that disturbed them. Certified Nursing Assistant #1 may not have been aware of the preferences, which could be the trigger for Resident #1's behavior that was not at their baseline. Based on their investigation there is insufficient evidence to conclude that abuse, neglect or mistreatment may have occurred on the part of the facility. During an interview on 05/29/2026 at 9:25 AM, Certified Nursing Assistant #1 stated they were assigned to Resident #1 on 05/27/2025 on the evening shift (3:00 PM-11:00 PM). Certified Nursing Assistant #1 stated they introduced themself to Resident #1 and served them dinner with no issues. Certified Nursing Assistant #1 stated at approximately 10:10 PM, they answered the call light of Resident #1, and they requested, to be changed. Certified Nursing Assistant #1 stated they asked Resident #1 what side they preferred to be turned on and Resident #1 chose their right side. Certified Nursing Assistant #1 stated Resident #1 observed to be full of feces and they started cleaning them, and while cleaning them, Resident #1 suddenly started yelling and kicking. Certified Nursing Assistant #1 stated they used a soft cleaning cloth because the resident has delicate skin. Certified Nursing Assistant #1 stated they do not know why Resident #1 suddenly had an outbreak. Certified Nursing Assistant #1 stated Resident #1 turned on their back, sat up in bed and continued to swing their arms hitting them (Certified Nursing Assistant #1). Certified Nursing Assistant #1 stated they used the palm of their hands to hold Resident #1's wrist trying to calm the resident down, while telling them they were not there to hurt them. Certified Nursing Assistant #1 stated they did not scratch the resident's arm, did not touch nor hit the resident's nose. They did not hurt Resident #1 at all. Certified Nursing Assistant #1 stated they stayed with the resident and called for the nurse. During an interview on 05/28/26 at 12:24 PM, Registered Nurse Supervisor #1 stated Licensed Practical Nurse #1 reported to them on 05/27/2025 (unsure of time) that Certified Nursing Assistant #1 hit Resident #1's nose and scratched their arm. Registered Nurse Supervisor #1 stated they assessed Resident #1 and observed a 2-centimeter skin tear over the purpura area of their left forearm and a 1-centimeter swelling over the bridge of their nose. Registered Nurse Supervisor #1 stated Resident #1 complained of pain (unable to recall the pain scale) and was given pain medication with relief. Registered Nurse Supervisor #1 stated they placed Resident #1 on one-to-one supervision. Registered Nurse Supervisor #1 stated they notified Nurse Practitioner #1 (on call), Director of Nursing, Administrator and family. Registered Nurse Supervisor #1 stated they removed Certified Nursing Assistant #1 from the unit and from the schedule pending investigation outcome, however Certified Nursing Assistant #1 did not return and was terminated from (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	the facility. Registered Nurse Supervisor #1 stated Resident #1 was sent to hospital for further evaluation and did not return to the facility.During an interview on 05/29/2026 at10:53 AM, Certified Nursing Assistant #2 stated they worked on 05/27/2025 on the 3:00 PM-11:00 PM shift. Certified Nursing Assistant #2 stated they observed a call light on in Resident #1's room and went to check. Certified Nursing Assistant #2 stated they observed Resident #1 agitated and crying and they asked Resident #1 what happened, and the resident reported that they asked Certified Nursing Assistant #1 to put their knitting supplies in their closet and not to put them in the bottom drawer and Certified Nursing Assistant #1 did not hang their clothes but instead folded them on the bed. Certified Nursing Assistant #2 stated Resident #1 has a special way of how they want their stuff (clothes etc.) to be in place. Certified Nursing Assistant #2 stated if the items are not placed how the resident wants them, it could trigger the resident to get upset. During an interview on 05/29/26 11:14 AM, the Director of Nursing stated they were notified of the incident on 05/27/2025 (unsure of time) by Registered Nurse Supervisor #1. The Director of Nursing stated Resident #1 became combative during care and Certified Nursing Assistant #1 held Resident #1's hands to prevent them from hurting each other. The Director of Nursing stated Certified Nursing Assistant #1 should have stopped when Resident #1 became aggressive and called the nurse. They stated Certified Nursing Assistant #1 should not have held Resident #1's hands. The Director of Nursing stated that Certified Nursing Assistant #1 took care of Resident #1 and transferred them to bed without any issues prior to the incident. The Director of Nursing stated based on their investigation there was not enough evidence to confirm Certified Nursing Assistant #1 intentionally hit Resident #1. The Director of Nursing stated that Resident #1 was transferred to the hospital and the family member reported that Resident #1 sustained a linear fracture to their nose. The Director of Nursing stated the cause of fracture could have been done by Resident #1 when they were moving their hands back and forth. The Director of Nursing stated Certified Nursing Assistant #1 had short nails and a pair of silver metal bracelet that could have contacted Resident #1's skin. The Director of Nursing stated they held a Quality Assurance/an ad hoc committee meeting on 05/29/2025 and they reviewed the incident and root cause analysis which indicated Certified Nursing Assistant #1 was not familiar with Resident #1's preferences which might have triggered the resident's behavior. During an interview on 05/29/2026 at 12:05 PM, the Administrator stated they were notified of the incident on 05/27/2025 at approximately 10:35 PM by Registered Nurse Supervisor #1. The Administrator stated they went to the facility, and they also called 911. The Administrator stated they interviewed Resident #1 who reported that Certified Nursing Assistant #1 hit them. The Administrator stated they interviewed Certified Nursing Assistant #1, who reported that they were providing care to Resident #1 when the resident started flailing their hands towards them. Certified Nursing Assistant #1 reported to them that when they grabbed the resident's hands, the resident's hands slipped out of their (Certified Nursing Assistant #1) hands and accidentally hit the resident on their nose. The Administrator stated Certified Nursing Assistant #1 demonstrated how Resident #1's arms were moving in all direction and how they held Resident #1's hands. During an interview on 05/29/2026 at 1:24 PM, the Medical Director stated they were notified about the incident by the Director of Nursing on 05/28/2025 (unsure of time). The Medical Director stated that they are aware Resident #1 has dementia and brittle bones, and that they believe Resident #1 could have possibly hit themself or the side rail, sustaining the fracture, when they were fighting and turning in their bed or when Certified Nursing Assistant #1 was holding them while they were fighting. During a follow up interview on 06/24/2026 at 10:15 AM, Certified Nursing Assistant #1 stated Resident #1 asked them to take their personal bag with their clothes off their bed and put the bag on the chair, then later asked them to put the bag on the bottom shelf in the closet. Certified Nursing Assistant #1 stated that Resident #1 did not ask them to hang or fold any clothes. Certified Nursing Assistant #1 stated they do not know why Resident #1 became combative with them. 10 New York Codes, Rules, and Regulations 415.4(a) (2-7)The facility took immediate corrective actions and was found to be in substantial compliance on 05/30/2025 prior to surveyors onsite (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	05/28/2026.Immediate Corrective Actions: On 05/27/2025 at 10:25 PM- Registered Nurse Supervisor #1 was notified and assessed Resident #1. Resident #1 was placed on one-to-one supervision.On 05/27/2025 at 10:30 PM- Resident Representative, Director of Nursing and Administrator were notified. On 05/27/2025 at 11:15 PM- Administrator visited the facility and called the local police. 05/27/2025 - Certified Nursing Assistant #1 was immediately suspended pending investigation outcome. 05/28/2025 at 12:00 AM- Resident #1 transferred to hospital for further evaluation. 05/28/2026 - staff statements via telephone re-interviewed by Director of Nursing, Assistant Director of Nursing, and Administrator.05/28/2025- 05/30/2025- Facility wide in-service on abuse prevention, customer service and caring for the resident with behavior. Lesson Plan and attendance sheets reviewed. 05/29/2025 - Quality Assurance meeting was held to review the incident, identify immediate corrective actions, root cause analysis and implement facility wide interventions.05/29/2025- policy and procedure titled Abuse Policy dated 06/01/2024 reviewed with no revisions.05/29/2025- policy and procedure titled Accident-Incidents dated 06/01/2024 reviewed with no revisions.05/29/2025- policy and procedure titled Resident Rights dated 05/2024 reviewed with no revisions.05/29/2025- Additional signs posted throughout the facility with the Administrator and Director of Nursing contact information for visitors and staff to easily report abuse and neglect 24 hours seven days a week. 05/29/2025-06/08/2025- Director of Nursing generated the lists of residents who were cared for by Certified Nursing Assistant #1 for the past two (2) weeks. The lists were used by the registered nurses to audit and identify any new skin breaks. The care plan for risk for skin impairment updated to reflect that if resident is combative STOP and report to the nurse promptly. This information was conveyed to all staff including certified nursing assistants through the facility wide in-service. Braden Scale (an assessment tool used to predict risk of developing pressure ulcer) will be completed for the residents on the list. 05/29/2025 to 12/29/2025- An audit interview tool created to identify residents' potential for abuse. Audit interviewed 10 random residents weekly x 4 weeks, then 20 random residents monthly x 3 months, then 60 random residents quarterly. On 06/04/2025- Ad hoc Resident Council meeting to discuss residents' rights and protection from resident abuse. Attendance of residents reviewed. On 06/30/2025- a follow-up Quality Assurance meeting was held. Attendance sheets reviewed. On 08/30/2025 - a Quality Assurance meeting was held to discuss freedom from abuse. Findings of plan of correction on the incident 05/27/2025 were discussed. Audits ongoing. On 11/24/2025- a Quality Assurance meeting was held, discussed continuation on abuse prevention education, continues abuse audit tool on other units, and staff education on activities of daily living care. Total number of staff: 303Facility Wide In-ServiceDepartmentCompleted % CompleteAdministrative1100% Registered Nurse17100%Licensed Practical Nurse31100%Certified Nursing Assistant 147100%Rehabilitation21100%Recreation6100%Security5100%Director of Nursing 1100%Assistant Director of Nursing1100%Social Worker4100%Pastoral Care2100%Human Resource1100%Staffing Coordinator1100%Medical Records1100%Clinical Coordinator1100%Receptionist2100%Maintenance 5100%Finance 2100%Dietary 32100%Housekeeping 22100% TOTAL303