

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335015	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Schervier Nursing Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2975 Independence Ave 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38306</p> <p>Based on observation, record review, and interviews during an abbreviated survey (NY00341219), the facility did not ensure a resident was adequately supervised to prevent accidents. This was evident in one (1) out of three (3) residents sampled (Resident #1). Specifically, on 05/02/2024 at 1:00 PM, Resident #1 who was cognitively declining left the facility unescorted for a self-arranged clinic appointment without the knowledge of the facility's nursing staff. Resident #1 's wheelchair was bumped by a truck while crossing the street. Resident #1 had right elbow pain but there were no fractures.</p> <p>The Findings are:</p> <p>The facility's Elopement and Wandering policy dated June 2023, documented the purpose of the policy is to prevent occurrences of residents leaving the facility undetected. Elopement is defined in the policy as when a resident goes beyond the safe environment of the clinical area and exits the building undetected without proper authorization. The policy also states that an interdisciplinary team assesses residents on admission and on a quarterly basis and whenever a significant change in a resident's status was noted and team members may care plan specific interventions to promote resident safety.</p> <p>The facility 's Occurrence Investigation dated 05/02/2024 10:00 PM, documented Licensed Practical Nurse #1 on the evening shift was unable to locate Resident #1 while administering evening medications. Resident #1 left the facility without a pass and boarded an assess- a- ride for a self-scheduled appointment at a clinic without informing the facility staff. Resident #1 was hit by a vehicle while crossing the road and was transferred to the emergency room .</p> <p>The Facility's Internal Investigation dated 05/07/2024 documented on 05/02/2024, Resident #1 was alert and oriented x three, scheduled their own appointments and make their own transportation arrangement. On 05/02/2024, Resident #1 left the facility and on arrival at the clinic, they did not have an appointment. Resident #1 was on their way back to the facility when crossing the road, their wheelchair was hit by another vehicle. Resident #1 fell , hit their elbow and was taken to the emergency room . There was no negative outcome from the fall and Resident #1 returned to the facility on [DATE]. The staff was not aware that Resident #1 was not in the building, Resident #1 was not an elopement risk.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident # 1 was admitted with Diagnoses including Depression, (feeling of sadness), bipolar disorder, (mood swings), and Multiple Myeloma (blood cancer) and a history of hearing loss to both ears.</p> <p>The Quarterly Minimum Data Set (resident's assessment tool) dated 03/08/2024, documented Resident #1 was moderately cognitive impaired. Resident #1 had difficulty keeping track of conversations and needed assistance with transfers and walking.</p> <p>Care plans for Cognitive, Behavior and Activities of Daily Living initiated on 01/05/2024. The interventions include monitoring the resident's mood and focusing on words and phrases and whether they make sense. Activities of Daily Living interventions includes Resident #1 required staff assistance with transfers.</p> <p>A Physician's orders for activity dated 01/05/2024, documented Resident #1 may go out on pass with responsible person as requested. May go out on pass for recreational activities and may go on appointments.</p> <p>A Behavior Care Plan initiated on 03/20/2024, documented Resident #1 will schedule appointments and arranging transportation independently and inform staff. The interventions included intervening as necessary to assist Resident #1.</p> <p>A Psychiatric Consultation note dated 04/09/2024, documented the hospital request a follow up appointment for Resident #1 who was hallucinating. Resident #1 's mood was depressed with irritable depressed speech. Resident #1 was diagnoses with Relapsed Depression with Bipolar Disorder. The medication was adjusted with a follow-up appointment scheduled for one (1) week.</p> <p>A Nurses late entry Health Status Note dated 05/02/2024 at 11:39 PM, written by Registered Nurse Supervisor #1 documented Resident #1 left the facility without a pass 05/02/2024. Resident #1 took an Access-A Ride to a self-scheduled appointment and did not inform the staff. Access-A Ride was called and informed the facility Resident #1 was taken to a clinic. A call was made to the clinic, and they were informed Resident #1 was in the hospital emergency room .</p> <p>The emergency room After Visit Summary dated 05/02/2024, documented Resident #1 arrived in the emergency room [DATE] at 9:16 PM, via Emergency Services (911) escorted by a healthcare worker. Resident #1 complained of right elbow pain and stated while crossing the street their wheelchair was bumped by a slow-moving truck, and they fell on their right elbow. It was documented Residents #1' adult child (Complainant) was informed and stated Resident #1 had a period of confusion and should not have left the nursing home unaccompanied. The X-rays of the right elbow, forearm, and humerus were negative for fractures.</p> <p>A Summary of Counseling to Security Guard #1 dated 05/03/2024, documented Security #1 observed Resident #1 leaving to an appointment and failed to verify whether Resident #1 had an appointment and where Resident #1 was going.</p> <p>During a telephone interview on 02/20/2025 at 11:55 AM, the Complainant (adult child of Resident #1) stated they received a phone call on 05/02/2024 about 10:00 PM, Resident #1 was missing from the nursing home. Complainant stated they reviewed the close circuit cameras with the nursing home's administration and saw Resident #1 getting into the Access-a Ride at about 1:00 PM on 05/02/2024.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/18/2025 at 4:45 PM, Certified Nursing Assistant #1 on evening shift (3PM-11PM) stated they served dinner in Resident #1's room, but Resident #1 was not in the room. License Practical Nurse #1 was informed them Resident #1 was not in their room.</p> <p>During a telephone interview on 02/25/2025 at 11:45 AM, Security Guard #1, stated residents are required to have a pass signed by the nurse on their floor and the pass is taken by the escort to the security guard at the desk. The escort signs the pass, and the escort goes with the resident via the designated transportation. Security Guard #1 stated they do not recall writing a statement and may have told a nurse that they saw Resident #1 leave in a cab, but they do not remember which nurse, time or which shift.</p> <p>During a telephone interview on 02/20/2025 at 1:40 PM, Licensed Practical Nurse #1 stated on 05/02/2025, they worked as an agency nurse on Resident #1's unit giving out medications. Resident #1 was not in their room and the Nursing Supervisor #1 was informed.</p> <p>During an interview on 2/18/2025 at 5:30PM, the Nursing Home Administrator stated Resident #1 usually makes their own appointments and takes Access-A Ride, but they were not told Resident #1 had an appointment. After reviewing the cameras, they saw Resident #1 getting into an Access-A Ride. They called Access-A Ride and were informed they brought Resident #1 to the clinic where Resident #1 usually goes for appointments. They were advised to call the hospital emergency room . The emergency room said Resident #1 was there after an accident while crossing the street.</p> <p>During an interview on 02/18/2025, Security Guard #2 stated they have been at the facility as security guard for one month. Stated also that at the nursing home's front desk there are photographs and lists of residents at risk for elopement and who wears wander guards. Resident #1 was not considered at risk for elopement but usually goes out on appointments with an escort. Security Guard #1 should have stopped Resident #1 from getting into the Access-A Ride or cab without a pass or an escort.</p> <p>10 NYCRR 415.12(h)(2)</p>		