

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024
NAME OF PROVIDER OR SUPPLIER Hebrew Home for the Aged at Riverdale		STREET ADDRESS, CITY, STATE, ZIP CODE 5901 Palisade Avenue Riverdale, NY 10471	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39365</p> <p>Based on observation, record review, and interviews conducted during an abbreviated survey (NY 00336157, NY 00331163, and NY 00308371), the facility did not ensure that all allegations of abuse, neglect, exploitation, or mistreatment were reported in a timely manner to local law enforcement, and to the New York State Department of Health in accordance with federal and state regulations. This was evident in three out of three residents sampled for abuse (Resident #1, Resident #2, and Resident #3). Specifically, on 01/01/24, between 1:00 pm and 2:00 pm, Resident #1's adult child reported to the facility that Resident #1 complained on 12/31/23, in the evening, Certified Nurse Assistant #1 pulled their hair and broke the fingernail on their left thumb. The facility did not report the incident to the New York State Department of Health or to local law enforcement.</p> <p>Specifically, on 03/08/24 at 11:15 am, Resident #2 complained that on 03/05/24, while in the rehabilitation gym, Physical Therapist #1's private body part was close to their right hand. The facility did not report the incident to the New York State Department of Health or local law enforcement.</p> <p>Specifically, on 01/08/23 at approximately 2:00 pm, a family member alleged that on 01/06/23 at 7:00 pm, Certified Nursing Assistant #2 slapped Resident #3 because they did not go to bed. On 01/09/23 at 1:48 pm, The facility reported Resident #3's allegation of physical abuse to the New York State Department of Health and did not report the alleged abuse to the law enforcement.</p> <p>The findings are:</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Facility's Policy and Procedure entitled Investigation and Reporting of Abuse, Neglect, Exploitation, Misappropriation of Resident Property and Other Incidents, revision date 02/24. It is a facility's policy that staff immediately report all events involving abuse, neglect, exploitation, mistreatment, or misappropriation of resident property, any reasonable suspicion of a crime against a resident of the facility, all incidents of unknown source, alleged or suspected quality of care issues, physical environment incidents, and death not due to natural causes. This document stated that all allegations/occurrences of all types of staff-to-resident abuse must be reported to the administrator and to other officials, including the New York State Department of Health and Adult Protective Services. The time frames for reporting to the New York State Department of Health and Local Law Enforcement (if applicable) are: Serious Bodily Injury 2 Hour Limit. If the events that cause the reasonable suspicion of a crime against a result in serious bodily injury to the resident, the report must be made immediately to the New York State Department of Health and local law enforcement, but not later than 2 hours after forming the suspicion. All others are within 24 Hours, if the events that cause the reasonable suspicion of a crime do not result in serious bodily injury to a resident, the report must be filed with the New York State Department of Health.</p> <p>The Facility's Policy and Procedure entitled Prohibition and Prevention of Resident Abuse, Neglect, Exploitation, Misappropriation of Resident Property, revised date 02/24, documented, all staff are required to report all incidents to the Director of Nursing. Staff are also required to report reasonable suspicion of a crime to the New York State Department of Health and to Local Law Enforcement.</p> <p>Resident #1 was admitted to the facility with diagnoses including Major Depressive Disorder, Aphasia (unable to speak), and anxiety disorder.</p> <p>The Minimum Data Set (assessment tool) dated 12/20/23, documented Resident #1 had a Brief Interview of Mental Status (used to determine attention, orientation, and ability to recall information) and scored 3 out of 15, indicating severely impaired cognition.</p> <p>A Grievance Complaint dated 01/02/24, documented on 01/01/24 (no time was documented), Resident #1's adult child complained to Registered Nurse #1 that Resident #1 told them on 12/31/23 in the evening, Certified Nursing Assistant #1 pulled their hair and caused fingernail on their left thumb to break. Resident #1 was assessed, and it was noted that the left thumbnail was a little broken off. No complaints of pain or bleeding was noted. No skin bruises or breaks were noted. Resident #1 has aphasia and was not consistent with the story. Certified Nursing Assistant #1, who worked double shifts on 12/31/23 (3-11 and 11-7), denied pulling Resident #1's hair or breaking their nail. There were no witnesses from staff or other residents. The facility concluded that there was no evidence of abuse, neglect, or mistreatment.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/28/24 at 1:35 pm, the Director of Nursing stated that on 01/01/24 between 1:00 pm and 2:00 pm, Resident #1 and their family reported to Registered Nurse #1 that Certified Nursing Assistant #1 pulled their hair and broke their nail on 12/31/23, during the evening shift. The Director of Nursing stated Registered Nurse #1 reported to the Nurse Manager #1. The Director of Nursing stated Nurse Manager #1 did not report to them until 01/02/24. The Director of Nursing stated Nurse Manager #1 should have informed them or their designee about the allegation immediately. The Director of Nursing stated that they and the Administrator or designee are responsible for reporting incidents of abuse to the New York Department of Health and to local law enforcement within two hours if there is suspicion of crime. The Director of Nursing stated they did not report the incident to the New York Department of Health and local law enforcement because there was nothing to report, because they immediately decided that abuse did not occur.</p> <p>During an interview on 05/28/24 at 3:04 pm, the Administrator stated that the Director of Nursing is the abuse coordinator and primary contact of abuse allegations and oversees the investigation. The Director of Nursing is responsible for reporting abuse allegations. The Administrator stated they were informed about Resident #1's allegation by the Director of Nursing on 01/02/24 (don't recall the time). The Administrator stated they discussed the case, investigation status, and reporting status. The Administrator stated the incident was not reported to the Department of Health and the police because they did not feel it was reportable because there was no evidence of abuse. The Administrator stated that allegations of abuse should be reported within two hours to the Department of Health. The Administrator stated Police should be notified when there is reasonable suspicion of a crime.</p> <p>Resident #2 was admitted to the facility with diagnoses including Malignant Neoplasm of the Brain (Brain Cancer), Difficulty Walking, and Pain.</p> <p>The Minimum Data Set, dated dated dated [DATE], documented Resident #2 had a Brief Interview of Mental Status and scored 14 out of 15, indicating intact cognition.</p> <p>A review of the facility's Internal Investigation dated 03/08/24, documented that Resident #2 told Transporter #1 on 03/07/24 they were not comfortable around Physical Therapist #1. Transporter #1 then informed the Director of Nursing on 03/08/24 at around 11:15 am. Resident #2 was interviewed and claimed that last Tuesday (03/05/24), while they were in the rehabilitation gym, Physical Therapist #1, had their penis close to Resident #2's right hand. The facility investigated the incident and concluded that there was no evidence of abuse, neglect, or mistreatment had occurred.</p> <p>During an interview on 5/24/24 at 12:46 pm, Registered Nurse #1 stated they got a call from the Assistant [NAME] President of Resident Engagement on 03/08/24 due to Transporter #1 reported that Resident #2 told them they were uncomfortable with Physical Therapist #1. Registered Nurse #1 stated they and the Assistant Director of Nursing interviewed Resident #2, who said that they were in rehabilitation unit on 03/05/24, their right hand was holding onto something, and the Physical Therapist #1 was standing at the front of them with their penis close to their right hand and was rubbing to their right hand. Registered Nurse #1 stated Resident #2 said Physical Therapist #1 was not exposed. Registered Nurse #1 stated they reported to the Director of Nursing, but did not call the police.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/28/24 a 1:35 pm, the Director of Nursing stated they were informed about the allegation in the rehabilitation unit on 03/08/24 between 11:30 and 12:00 pm and reported to the Administrator. The Director of Nursing stated they did not report the incident to the New York Department of Health because there was no violation. The Director of Nursing stated the incident did not happen, they investigated immediately, and there were a lot of witnesses in the rehabilitation unit that said Physical Therapist #1 did not sexually abuse Resident #2. The Director of Nursing stated police were not called because there was no reasonable suspicion of a crime, it was ruled out immediately.</p> <p>Resident #3 was admitted to the facility with diagnoses including Anxiety, Depression, Behavioral and Psychiatric Disturbances.</p> <p>The Minimum Data Set, dated dated dated [DATE], documented that Resident #3 had a Brief Interview for Mental Status and scored 11 out of 15, indicating moderate cognitive impairment.</p> <p>The facility's Investigation Summary dated 01/08/23, documented on 01/07/23 at 7:00 pm, Family Member reported that Certified Nursing Assistant #3 clapped Resident #3 when they did not go to bed. The family member stated that Resident #3 called them on 01/07/23 at 7:00 pm. Registered Nurse Supervisor #1 interviewed Resident #3, who stated that it was not 7:00 pm when they were slapped in the face but at 11:30 pm that night when they were going back to bed. The investigation also documented Resident #3 was immediately assessed by Registered Nurse Supervisor #1, and there was no redness, no swelling, and no skin break was noted on Resident #3's face. The investigation concluded that the allegation was unfounded, Resident #3 was assisted by two staff members and neither witnessed the incident.</p> <p>The form Submission from Nursing Home Facility Incident Report documented that the Nursing Home Facility Incident Report was submitted on 01/09/2023 at 1:48 pm.</p> <p>During an interview on 05/29/24 at 9:19 am, Registered Nurse Supervisor #1 stated they reported the allegation to the Assistant Director of Nursing Services and Director of Nursing on 01/08/2023 via telephone. Registered Nurse Supervisor #1 stated all abuse must be reported to the New York State Department of Health within 2 hours with injury or no injury.</p> <p>During an interview on 05/24/2024 at 4:07 pm, the Assistant Director of Nursing Services stated the facility must report all abuse if there is injury within two hours and if there is no injury within twenty-four hours to the New York State Department of Health. The Assistant Director of Nursing Services stated they reported the allegation to the New York State Department of Health within twenty-four hours and did not report it to law enforcement.</p> <p>During an interview on 05/24/2024 at 3:48 pm, the Administrator stated they became aware of the allegation by the Director of Nursing on 01/09/23. The Administrator stated the alleged incident was reported to the New York State Department of Health by the Assistant Director of Nursing Services on 01/09/23, which was within the two-hour window. The Administrator stated the facility reports abuse to the New York State Department of Health within two hours if there are injuries, and if no injuries within twenty-four hours.</p> <p>10 NYCRR 415.4(b)(2)</p>		