STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335028	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Citadel Rehab and Nursing Ctr at Kingsbridge	3400 -26 Cannon Place 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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49081 Based on observation, record review, and interviews conducted during an Abbreviated Survey (NY00335650), the facility failed to provide adequate supervision to a resident to prevent accidents. This was evident for one (1) of three (3) residents (Resident #1) sampled. Specifically, on [DATE] at 11:00 AM, Resident #1 fell off their bed onto the floor while Certified Nursing Assistant #1 was providing bed mobility care by themself. Registered Nurse Supervisor #1 assessed Resident #1 to have swelling of their right elbow, and complaints of pain to their head, right arm, elbow, and back. Resident #1 was transferred to the hospital on [DATE] at 2:55 PM and was admitted to the hospital with diagnoses of right arm and pelvis fracture. The Resident Nursing Instructions dated [DATE] documented Resident #1 was dependent (two (2) or more helpers are required) for bed mobility. Certified Nursing Assistant #1 did not review Resident #1's Resident Nursing Instructions before providing care to Resident #1. This resulted in actual harm to Resident #1 with the potential for serious injury, serious harm, serious impairment, or death to 15 residents on the unit who are dependent for bed mobility, that was not Immediate Jeopardy. The findings include: The facility policy titled Falls and Fall Risk, revised ,d+[DATE], documented staff to identify interventions related to the resident's specific risks and causes of falls, to prevent the resident from falling, and to try to minimize complications from falling. The facility's policy titled Accident/Incident Investigation, revised on ,d+[DATE], defined accident as an uncontrollable event that results in unintentional injury that requires therapeutic intervention. Examples include, but are not limited to, laceration (a deep, long cut), contusion, fractures, ecchymosis, second- and third-degree burns, and any head trauma (with or without visible injury). Incident was defined as an uncontrollable event that results in no injury or superficial injury. Examples include, but are not limited to, scratches, scrapes, and blisters, reddened area with no swelling or pain, falls with no injury, first degree burns, and skin tears. The policy titled Assignment of Care, with a review date of ,d+[DATE], documented that it was the responsibility of all nursing personnel to check the assignment and accountability section at the start of the shift for their daily assignment. Resident #1 was admitted to the facility with diagnoses including Non-Alzheimer's Dementia, Osteoarthritis of Bilateral Shoulders, and Osteoporosis. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335028	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2025
NAME OF PROVIDER OR SUPPLIER: The Citadel Rehab and Nursing Ctr at Kingsbridge		STREET ADDRESS, CITY, STATE, ZIP CODE: 3400 -26 Cannon Place Bronx, NY 10463	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	The Minimum Data Set, dated dated dated [DATE] documented Resident #1 had severe cognitive impairment. Resident #1 was identified as being dependent (helper does all the effort. Resident does none of the effort to complete the activity or the assistance of two (2) or more helpers is required for the resident to complete the activity) with roll left and right (the ability to roll from lying on back to left and right side and return to lying on back on the bed). An Activities of Daily Living Self- Care Performance Deficit Care Plan dated [DATE] documented Resident #1 was assessed to be dependent for bed mobility. The Care Plan Note dated [DATE] documented staff reported Resident #1 now required two-person assist for bed mobility. The Resident Nursing Instructions dated [DATE] identified Resident #1 to be dependent for bed mobility. An Accident/Incident Investigation Report dated [DATE] at 11:00 AM documented Resident #1 had fallen off their bed onto the floor while Certified Nursing Assistant #1 was providing bed mobility care to Resident #1 by themself. Registered Nurse Supervisor #1 assessed Resident #1 to have right elbow swelling and complaints of pain to the head, right arm, elbow, and back. Resident #1 was transferred to the hospital on [DATE] at 2:55 PM. The investigation concluded that abuse and neglect had occurred. A nursing note by Registered Nurse #1 dated [DATE] at 3:10 PM documented Resident #1's right arm appeared to be more swollen, and Resident #1 continued to complain of pain. Resident #1's family member requested for Resident #1 to be transferred to the hospital for evaluation. Tramadol 25 milligram tablet was given at 1:40 PM. Resident #1 left the facility at 2:55 PM via ambulance. A nursing note by Registered Nurse #2 dated [DATE] at 10:50 PM documented facility received report from hospital Emergency Department that Resident #1 was admitted with diagnosis of arm and pelvic fracture. Review of an Emergency Department to Hospital Admission (Discharge) document dated [DATE], revealed Resident #1 sustained an acute fracture of the posterosuperior T12 vertebral body, acute mildly displaced fractures of the pelvis and right sacral area, and an acute displaced transverse fracture of the right upper arm. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 10:00 AM, Certified Nursing Assistant #1 stated they floated to Resident #1's unit on [DATE] on the day shift and was assigned to Resident #1. Certified Nursing Assistant #1 stated that the other Certified Nursing Assistants (no names mentioned) on the unit told them Resident #1 requires one (1) person to wash them and two (2) persons for transfer. Certified Nursing Assistant #1 stated on [DATE] at 11:00 AM they gathered all their supplies and placed them on Resident #1's wheelchair, which was at the foot of Resident #1's bed. Certified Nursing Assistant #1 stated they washed and turned Resident #1 by themself. When they turned Resident #1 on their left side towards them, they reached for the towel that was on the wheelchair at the foot of the bed. Suddenly, Resident #1 slid off the bed and fell on to the floor. Certified Nursing Assistant #1 stated they reported the accident to Licensed Practical Nurse #1. Certified Nursing Assistant #1 stated they did not have the bed rails up while they were providing care, did not review the Resident Nursing Instructions, and did not receive a report from the charge nurse prior to providing caring to Resident #1. Certified Nursing Assistant #1 stated they were not aware Resident #1 required two-person assistance for bed mobility. Certified Nursing Assistant #1 stated they had received in-service on reviewing the Resident Nursing Instructions prior to providing care. Certified Nursing Assistant #1 stated they buddied up with another Certified Nursing Assistant during orientation and received training on how to review the Resident Nursing Instructions prior to providing care. During an interview on [DATE] at 10:52 AM, Licensed Practical Nurse #1 stated they were the charge nurse on the unit on [DATE]. Licensed Practical Nurse #1 stated they were not aware Certified Nursing Assistant #1 was providing care to Resident #1 by themself. Licensed Practical Nurse #1 stated they went to Resident #1's room to perform wound care and when they opened the room door, they observed Resident #1 lying on the floor next to their bed. Licensed Practical Nurse #1 stated Resident #1 was in pain. Tramadol 25 milligram was administered and Registered Nurse Supervisor #1 was notified. Licensed Practical Nurse #1 stated Resident #1 did not have any visible injuries. Licensed Practical Nurse #1 stated they are responsible for monitoring the staff on the unit to ensure staff are following the residents' plans of care. Licensed Practical Nurse #1 stated the unit was not short staffed and that they gave the staff report at the beginning of the shift. Licensed Practical Nurse #1 went on to say that Certified Nursing Assistant #1 (who was new to the unit) also received a report pertaining to Resident #1's care. Registered Nurse Supervisor #1 is no longer employed in the facility and their whereabouts are unknown. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 3:00 PM, the Assistant Director of Nursing stated Certified Nursing Assistant #1 provided care to Resident #1 by themself without calling for another staff. Assistant Director of Nursing stated Resident #1 is totally dependent with two-person assistance for bed mobility, as indicated in the Activities of Daily Living care plan. The Assistant Director of Nursing stated that the Resident Nursing Instructions also mentioned Resident #1 was dependent for bed mobility. The Assistant Director of Nursing stated when they reviewed the Resident Nursing Instructions for Resident #1, it did not indicate how many staff were required to provide bed mobility care for Resident #1. However, Certified Nursing Assistant #1 received an in-service on Activities of Daily Living on [DATE], identifying that when a resident is totally dependent for care, they require two (2) or more staff assistance to complete the care. The Assistant Director of Nursing stated Certified Nursing Assistant #1, who has been employed by the facility for six months, was trained and given instructions to get a report from the charge nurse and to call for assistance. The Assistant Director of Nursing stated Certified Nursing Assistant #1 was responsible for reading the Resident Nursing Instructions prior to providing care. The Assistant Director of Nursing stated the nurse on the unit and the Nursing Supervisors are responsible for monitoring the staff to ensure care is being provided as indicated on the plan of care. They stated the facility concluded that neglect had occurred; the fall was avoidable, and Certified Nursing Assistant #1 should have asked for assistance from other staff during care. During an interview on [DATE] at 10:00 AM, the Administrator stated that they were notified of the incident on [DATE] by the Assistant Director of Nursing and Director of Nursing. The Administrator also stated that law enforcement was notified and came to the facility, where they took a report. The Administrator stated that Certified Nursing Assistant #1 was suspended and subsequently terminated for not following the plan of care. The Administrator stated that their view of the incident is that the facility is not culpable because Certified Nursing Assistant #1 received relevant training and in-services prior to the incident. During an interview on [DATE] at 2:56 PM, Nurse Practitioner #1 stated that they were notified of the accident and assessed Resident #1, who was observed with swelling to their right arm and complaints of pain. Nurse Practitioner #1 stated that they had ordered an x-ray and notified Resident #1's family member, who requested Resident #1 to be transferred to the hospital. Nurse Practitioner #1 stated the accident could have been avoided if Certified Nursing Assistant #1 had requested help. 10NYCRR 415.12(h)(1)