STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335030	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mosholu Parkway Nursing & Rehabilitation Center	3356 Perry Avenue Bronx, NY 10467

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43350 Based on interviews, observations and record reviews made during the Recertification and Complaint Survey (NY00330894) from 8/12/24 to 8/16/24 the facility did not ensure that an alleged of abuse was thoroughly investigated. Specifically, a resident (Resident #12) with a reported injury of unknown origin had only one written statement gathered from staff and no written investigation summary. The findings are: The facility's policy and procedure entitled Investigating Unexplained Injuries, last reviewed 12/2018, documents that a listing of all personnel including consultants, contract employees, visitors, family members etc. who have had contact with the resident during the past 24-48 hours will be compiled and provided to the person conducting the investigation. Resident #12 was admitted to the facility on [DATE] with diagnoses including Osteoporosis, Repeated Falls and Alzheimer's Disease. A Nursing progress note dated 01/01/2024 at 4:13 PM documents the resident was observed with a linear scratch across their left cheek. An Occurrence Report dated 01/01/2024 at 2:50 PM documents that a physical assessment was completed and the unit physician was notified. A written statement was provided by a Certified Nursing Assistant who stated that they had become aware of the incident at 2:30PM and had last seen the resident at 1:00 PM when they provided care to the resident along with the unit nurse. No other employee statements were documented. The Occurrence Report was signed by the Director of Nursing on 01/03/2024 and documented that the resident had a history of grabbing onto items and, on assessment, was observed to have a sharp edge to one of their fingernails. A check box documented that Determination of Investigation was that no abuse or mistreatment had occurred. However, no investigation summary was documented. Staffing sheets were reviewed for 12/31/2023 and 01/01/2024 and revealed that the staff member named in the Occurrence Report had not worked anywhere in the facility on either of those dates. (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: 335030	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/16/2024
NAME OF PROVIDER OR SUPPLIER: Mosholu Parkway Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 3356 Perry Avenue, Bronx, NY 10467	

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/15/2024 at 8:11 AM, the Assistant Director of Nursing was interviewed and stated that the nursing supervisor is responsible for filling out the Incident Report but the facility doesn't have a regular supervisor on the day shift. The Assistant Director stated that when an Incident Report is done, employee statements are always gathered; however, the Director of Nursing at the time of the incident did not want anyone other than themselves to document any conclusions. On 08/15/2024 at 11:26 AM, the Director of Nursing was interviewed and stated that when an investigation of an injury is done, the facility starts with the shift at the time of the observation and goes backwards to establish a time frame for when the injury could have occurred. If the resident is able to explain what happened, they are interviewed, but in this case the resident was nonverbal for the most part. Their roommates are usually also interviewed to determine if they witnessed the incident, but in this case neither of the two roommates was alert. The Director stated that they were not working in the facility at the time of the incident and could not locate any other written statements. 10 NYCRR 415.4(b)(3)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39136 Based on record review and interviews conducted during the Recertification and Complaint (NY00330928, and NY00330894) Survey from 08/12/2024 to 08/16/2024, the facility did not ensure a person-centered comprehensive care plan was developed and implemented to meet a resident's needs. This was evident for 2 of 3 residents (Resident #76, and #85) reviewed for care planning out of 27 total sampled residents. Specifically, 1) A comprehensive care plan related to abuse was not developed and implemented for Resident #76 following a resident to resident altercation, and 2) A comprehensive care plan was not developed and implemented to address Resident #85 insulin use. The findings are. The facility's undated policy and procedure titled Care Plans, Comprehensive Person - Centered documented that a comprehensive person-centered care plans that include measurable objectives and time frame to meet resident physical psychosocial and functional needs is developed and implemented for each resident. 1) Resident #76 was admitted with the diagnoses that include Hypertension and Depression. The quarterly Minimum Data Set assessment dated [DATE] documented Resident #76's cognition as severely impaired and never/rarely made decisions. A Nurse's progress note dated 01/03/2024 at 3:59 PM documented that the writer was notified by the porter around 2:20 PM that Resident #24 slapped Resident # 76 in their face in the hallway during a verbal exchange. The facility Summary of Investigation dated 01/03/2024 concluded that there was evidence that abuse, neglect, mistreatment has occurred. There was no documented evidence that a comprehensive care plan was developed with interventions following the resident-to-resident altercation. On 08/16/2024 at 9:02 AM, the Assistant Director of Nursing was interviewed and stated that the registered nurses are responsible for initiating and updating care plans. I am not aware that Resident #76 had no abuse care plan in place. An abuse care plan should have been initiated when the incident occurred. Generally, they are supposed to run through the care plan and ensure that all the care plans are in place. On 08/16/2024 at 10:02 AM, the Director of Nursing was interviewed, and stated that after an incident, if an abuse care plan is in place, it will be updated; if there is no care plan, we will initiate one right away. I was unaware that the care plan was not initiated after the incident. They should have initiated abuse care plan after the incident. The social worker was responsible for ensuring that an abuse care plan was initiated after the incident. 43350 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Resident #85 was admitted to the facility on [DATE] with diagnoses including Diabetes Mellitus, Liver Cirrhosis and Schizoaffective Disorder. The resident's Minimum Data Set (a resident assessment tool) dated 08/14/2024 documented that the resident used hypoglycemic medication. A Physician's Order dated 08/13/2024 for Lantus U100 - 50 units at bedtime and an order dated 08/12/2024 for Humalog U100 - 15 units 3 times a day before meals were in place. The resident's care plans were reviewed and revealed that no care plans was in place for either Diabetes or Insulin Use. On 08/15/2024 at 8:11 AM, the Assistant Director of Nursing was interviewed and stated that when a resident is admitted , their baseline care plan must be completed within 48 hours of their admission and must reflect each of their diagnoses. The Registered Nurse is usually responsible for initiating the care plan, and it is reviewed at the resident's first interdisciplinary care plan meeting. In the case of Resident #85, the unit has no regular Registered Nurse and supervisors have been taking turns providing coverage. On 08/16/2024 at 11:26 AM, the Director of Nursing was interviewed and stated that each resident has an individual plan of care based on the resident's needs. Then each care plan is reviewed on a quarterly basis and is updated as needed. The Director was unable to state why Resident #85 had no Diabetes care plan and stated that it would have been an oversight. 10 NYCRR 415.11(c)(1)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43350 Based on record reviews and interviews made during the Recertification Survey from 8/12/24 to 8/16/24, the facility did not ensure that a person-centered comprehensive care plan was reviewed and revised to accurately reflect a resident's current status. Specifically, a resident with a new skin break (Resident #12) did not have their Skin Integrity Care Plan updated to reflect the change. The findings are: Resident #12 was admitted to the facility on [DATE] with diagnoses including Osteoporosis, Diabetes and Alzheimer's Disease. A Skin Integrity Care Plan was initiated for the resident on 09/19/2018 with interventions including: completing skin assessments, monitoring resident's skin during care, encouraging fluid intake and food consumption, keeping skin clean and dry, arranging podiatry consults, providing pressure relieving mattress and devices when out of bed, and applying barrier cream. A Nursing Note dated 01/01/2024 at 4:13 PM documents that Resident #12 was observed with a linear scratch across their left cheek. An Occurrence Report was initiated on 01/01/2024 in which it was noted that the resident's care plan had been updated. Resident #12's care plans were reviewed. Their Impaired Skin Integrity care plan was noted to have been updated on 01/05/2024 and documented that their skin was intact and made no mention of any scratch to their face. None of the resident's other care plans noted the scratch either. On 08/15/2024 at 8:11 AM, the Assistant Director of Nursing was interviewed and stated the usually the Registered Nurse on the unit is responsible for updating a resident's care plans. However, there is no regular Registered Nurse on duty on the day shift. Documentation of a scratch would either be found in the nursing notes or in the care plan. On 08/16/2024 at 11:26 AM, the Director of Nursing was interviewed and stated that they were not yet working in the facility when the incident with Resident #12 occurred. Care plans are reviewed quarterly to determine if updates are needed and are reviewed and updated when needed. The Director stated, In this case, the care plan should have been updated. 10 NYCRR 415.11(c)(2)(i-iii)

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F 0689 Level of Harm - Minimal harm or potential for 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** 43350 Based on interviews, observations and record reviews made during the Recertification and Complaint(NY00326358) survey from 8/12/24 to 8/16/24, the facility did not ensure that each resident received adequate supervision to prevent accidents. Specifically, on 10/18/2023, a resident (Resident #99) eloped from the facility. The findings are: The facility's policy and procedure entitled Wandering Resident/Elopement, last reviewed 04/20/2023, states that each resident will be assessed for wandering behavior and elopement potential on admission. The receptionist monitors the front door 24 hours a day. The front door is kept locked and can be opened by reception only. If the receptionist leaves the front desk for any reason or any period of time, a trained replacement employee must be stationed at the front desk. The reception person must assure that all visitors sign in and out in the designated log book at the reception area. Pictures of residents at risk are taken by nursing staff and posted at the front desk. Resident #99 was admitted to the facility on [DATE] with diagnoses including; Seizure Disorder, Vascular Dementia with Restlessness and Agitation. The Minimum Data Set 3.0 (a resident assessment tool) dated 10/09/2023 documented the resident as severely cognitively impaired. A Social Work note dated 10/04/2023 documents that prior to their admission, the resident had been living in a shelter in [NAME] and was for short-term placement. A Psychiatry Consult dated 10/06/2023 documents that the resident was very confused and restless, with poor attention and concentration, poor impulse control, poor insight and judgment, and had been taking Risperdal 1 mg twice a day for agitation. The Psychiatrist recommended that since the resident had no mental health diagnosis other than depression, the Risperdal be reduced and then discontinued. Instead, they recommended starting Mirtazapine 15 mg at bedtime and Trazodone 25 mg twice a day for depression. Nursing Notes dated 10/13/2023 and 10/17/2023 documented that the resident was observed wandering at night, once stating they were going to the store and the other time that they were going to the kitchen, and each time were returned to bed. A Nursing Note dated 10/18/2023 at 7:17 PM documents that a Code Grey was activated at about 2:00 PM when Resident #99 was reported missing. The premises inside and outside were searched, as was the surrounding neighborhood. The resident's family was contacted and provided their last known addresses, which were also checked. A Nursing Note dated 10/18/2023 at 10:05 PM documents that the resident was located at their previous shelter in [NAME] and was picked up and returned to the facility, having refused to be transported to the hospital for evaluation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nursing Note dated 10/18/2023 at 10:43 PM documents that the resident was fitted with a Wanderguard which was applied to their left arm and staff was made aware. The resident was confused and was unable to state how they had gotten from the Bronx to their residence in [NAME]. An Occurrence Report dated 10/18/2023 documents that the resident was reported missing at 2:40 PM. A written statement by the desk attendant documented that they stopped the resident at the exit and asked where they were going. The resident replied that they were a visitor and were leaving. The attendant, who was a porter filling in for a regular receptionist, allowed the resident to leave without checking the photos of new admissions at the desk or the visitors log. The entrance door was unlocked because the buzzer was not working. Following the incident, the porter was terminated. A Psychiatry Consult dated 10/19/2023 documents that the resident was seen following an elopement, was restless, depressed and very confused. The psychiatrist recommended increasing their dose of Trazodone to 50 mg twice a day to address depression and to consider Namenda 5 mg daily x 7 days, then increased to 5 mg twice a day, then 10 mg twice a day for confusion. An Elopement care plan was initiated for the resident on 10/18/2023 and last reviewed 07/16/2024 with a note stating that the resident's Wanderguard had been replaced. Interventions included checking the Wanderguard every shift, being aware of the resident's whereabouts at all times, ensuring hourly monitoring sheets were in use, involving the resident in recreation and encouraging them to eat in the main dining room or a visible area on the unit. On 08/15/2024 at 10:10 AM, Certified Nursing Assistant #7 was interviewed and stated that on 10/18/2023, the rehab therapist escorted the resident to the rehab gym after assisting them with morning care. The resident typically returned to the unit for lunch, and when the lunch trays were collected and the aide realized that Resident #99's tray had not been touched, they called rehab to see if the therapist had brought the resident to the main dining room after their session. Then the aide went to all the other units to search for the resident, went into all the bathrooms, the lobby and the basement. After this, they phoned the Director of Nursing, who called a Code Grey. The aide stated that they then checked the neighborhood down to the Number 2 subway station, the local supermarkets and Montefiore Hospital. The aide stated that after about a three-hour search, they went home, and upon entering the facility on 10/09/2023, they saw the resident back on the unit wearing a Wanderguard. The aide stated that they did not document the resident's whereabouts on any monitoring sheet and that the resident was not on a formal monitoring program following the elopement. On 08/15/2024 at 10:17 AM, Licensed Practical Nurse #5 was interviewed and stated to have been the charge nurse on the unit on 10/18/2023. The nurse stated that in the two weeks or so that Resident #99 had been in the facility, the resident always stayed in their room when they weren't in the rehab gym or the bathroom. There were no wandering episodes during the day and the hospital hadn't mentioned any in the admission paperwork. The nurse stated that therapy doesn't work with residents on a tight schedule, so when the resident was late for lunch on 10/18/2023, they assumed that they were still in the gym. But when the resident never returned to eat, a code was called and the resident was not found anywhere inside or outside the facility. The nurse stated that the resident is now monitored closely although not on a formal schedule and that they mostly stay in their room watching TV. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/15/2024 at 11:08 AM, the Occupational Therapist was interviewed and stated that on 10/18/2023, they were working with Resident #99 on ambulation with a Rollator and the safest way to enter and exit an elevator. They then returned the resident to the unit but did not endorse them to any unit staff. The Occupational Therapist stated, The next day when I came to work I was told the resident had eloped to their home, and they wrote me up, but they were self ambulatory. They checked the security video and it turned out that they eloped more than an hour after I brought them back to the unit. On 08/15/2024, two attempts were made to reach the porter who was at the main desk on 10/18/2023, at 12:26 PM and at 1:34 PM, but they were unsuccessful. On 08/16/2024 at 11:39 AM, the Director of Nursing was interviewed and stated that employees who are asked to sit at the reception desk are cross-trained to follow reception protocols. Photos are kept at the front desk of all known wanderers as well as all new admissions whose wandering behavior is unknown. and must be checked whenever there is a suspicion that a resident is attempting to elope. Anyone who notices that any locks are non-functional must immediately report it to Maintenance. 10 NYCRR 415.12(h)(2)