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	11/15/2024

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 39365 Based on observation, record review and interviews during the abbreviated survey (NY00312367), the facility failed to ensure that a resident was treated with dignity included being free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. This was evident in one out of three residents reviewed (Resident #1). Specifically, on 03/09/2023 at approximately 8:39 AM, Physical Therapist #1 observed Resident #1 in their room sitting in the wheelchair with a bed sheet wrapped around their waist and tied to the wheelchair. Registered Nurse Supervisor #1 assessed Resident #1 and there were no visible injuries. The findings included: The facility policy titled Restraint Free Facility with the revised date 03/01/2024, documented the purpose of this policy is to affirm the facility's commitment to being a restraint-free facility. The center is dedicated to ensuring the dignity, safety, and well-being of all residents by eliminating the use of chemical and physical restraints and implementing alternative interventions. Resident #1 was admitted to the facility with diagnoses including Dementia, a Stroke, and Unsteadiness on the feet. A Minimum Data Set (an assessment tool) dated 01/27/2023, documented Resident #1 had long and short-term memory impairment and severely impacted cognitive skills for daily decision-making. A facility investigation dated 03/09/2023, documented that at approximately 8:39 AM, Physical Therapist #1 went to Resident #1's room and observed Resident #1 sitting in the wheelchair with a bedsheet wrapped around their waist and tied to the wheelchair. The bedsheet was removed immediately. Registered Nurse Supervisor #1 was made aware and assessed Resident #1. There were no visible injuries and no signs or symptoms of pain. The Medical Doctor was informed and there were no new orders. Licensed Practical Nurse #1 was interviewed and stated that after around 20 minutes of unsuccessful redirections, they applied a restraint on Resident #1 for three to five minutes to prevent Resident #1 from falling or sustaining self-injury. The facility concluded that there might be some evidence of abuse or mistreatment. (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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Care Plan Potential for Resident Abuse initiated on 03/09/2023, documented interventions are to approach Resident #1 calmly and unhurriedly, speak in a calm voice, note any agitated behavior, do not force any activities. There are zero tolerance for abusive behavior of staff towards Resident #1. Instruct Certified Nursing Assistant to report any abnormal behavior or actions to the charge nurse. During an interview on 08/19/2024 at 1:20 PM, Certified Nursing Assistant #1, who was assigned to Resident #1 on 03/09/2023, during the 7:00 AM to 3:00 PM shift, stated on 03/09/2023, in the morning, Resident #1 were upset, agitated, and out of control, tried to walk but was unsteadily and was put in a wheelchair. Certified Nursing Assistant #1 stated they remembered when they came out of the room, at the front of the nursing station, they saw a sheet over Resident #1 and behind the wheelchair. Certified Nursing Assistant #1 stated they did not see if the bedsheet was tied. Certified Nursing Assistant #1 stated they told Licensed Practical Nurse #1 it was not the proper way to calm Resident #1 down. Licensed Practical Nurse #1 said it was to prevent Resident #1 from falling. During an interview on 10/24/2023 at 8:47 PM, Licensed Practical Nurse #1 stated they worked 8: 00 AM to 4:00 PM shift on 03/09/2023, and Resident #1 was already agitated, tried to get out of the wheelchair, and walked very unsteady. Resident #1 was at high risk for fall. Licensed Practical Nurse #1 stated Licensed Practical Nurse #2 from the night shift said they already called the Nursing Supervisor and Rehabitation Department, but no one had come yet. Licensed Practical Nurse #1 stated they don't remember if anyone called the doctor. It was breakfast time, and the staff was busy giving trays. Licensed Practical Nurse #1 stated they had never applied restraint before on Resident #1. Licensed Practical Nurse #1 stated it is not facility policy to restrain residents, but at that moment, it was the right technique to prevent Resident #1 from injuring themselves. Licensed Practical Nurse #1 stated they did not tighten any knots, just wrapped Resident #1 with a sheet in the wheelchair until Resident #1 calmed down and then the sheet was removed shortly after. During an interview on 10/24/2024 at 12:15 PM, Physical Therapist #1, who was working on 03/09/2023 8:00 AM to 4:00 PM shift, stated they were doing the morning observations and went to the Resident #1's room (don't recall the time). Physical Therapist #1 stated they observed Resident #1 sitting in the wheelchair with a white bedsheet wrapped around their waist and tied at the back of the wheelchair. Resident #1 was confused and stressed. There was no one in the room besides Resident #1. Physical Therapist #1 stated they were surprised because it was a restraint. Physical Therapist #1 stated they untightened the knot and removed the bedsheet from Resident #1. Physical Therapist #1 stated the wheelchair was also tightened with something to the bed. Physical Therapist #1 stated they freed the wheelchair and wheeled Resident #1 to the nursing station, notified Licensed Practical Nurse #1 of the findings. Physical Therapist #1 stated they took Resident #1 by walking with them to the gymnasium and reported to the Rehabilitation Supervisor. During an interview on 10/24/2024 at 1:25 PM, Licensed Practical Nurse #2 stated they worked from 12:00 AM to 8:00 AM, at 8:00 AM, when Licensed Practical Nurse #1, who came on duty, called them for help after and they stayed to help and talk to Resident #1. Licensed Practical Nurse #2 stated Licensed Practical Nurse #1 put a bedsheet around Resident #1's waist from side to side of the wheelchair without tying any knots. Licensed Practical Nurse #2 stated that they did not witness any knots at the back of the wheelchair, and no one tied the wheelchair to the bed unless it happened after they left the unit. Licensed Practical Nurse #2 stated that wrapping Resident #1 in the bed sheet was not a proper technique, but it was done to prevent falls because Resident #1 was agitated and unsteady on their feet and became dangerous to themselves and others. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/19/2024 at 12:38 PM, the Assistant Director of Nursing stated they were Registered Nurse Supervisors at the time of the incident on 03/09/2023. The Assistant Director of Nursing stated they became aware on 03/09/2023 at around 8:39 AM from the Rehabitation Manager, who notified them that one of their employees (Physical Therapist #1) witnessed Resident #1 being tied around the waist by the sheet. The Assistant Director of Nursing stated they went immediately, and no bed sheet was on Resident #1. The Assistant Director of Nursing stated Licensed Practical Nurse #1 should have called the Nursing Supervisor, and they would assign a one-to-one person to Resident #1 to walk with them for safety. The Medical Doctors should have been notified. The Assistant Director of Nursing stated they assessed Resident #1, and there were no visible injuries, redness, or marks. Resident #1 was walking around and not agitated and was given Rehabilitation therapy. The Medical Doctor was notified and there were no new orders. During an interview on 11/15/2024 at 11:00 AM, the Director of Nursing stated they were not working in the facility at the time of the incident. The director of Nursing stated the in-services and audits were done by the former Director of Nursing. The Director of Nursing stated all staff members on the units are responsible for ensuring residents remain free from restraint. The Director of Nursing stated all department heads do their observations every Monday and Friday. The Director of Nursing stated the supervisors do daily rounds to make sure the residents remain free from abuse and restraint. Practical Nurse #1 was disciplined, re-in-serviced, and terminated on 03/13/2024 for a different reason. The facility implemented corrective actions and was found to be in substantial compliance on 03/14/2023, prior to the start of the Abbreviated Survey on 08/19/2024. The facility was cited with past non-compliance, and the following Plan of Correction was implemented: The Physical Therapist removed the bedsheet from the resident immediately. Registered Nurse Supervisor #1 was made aware and assessed Resident #1. No visible injury was noted. No signs or symptoms of pain were noted. The medical doctor was informed, and no new orders had been given. Licensed Practical Nurse #1 was disciplined and re-in-serviced on abuse and restraint. Licensed Practical Nurse #1 was terminated on 03/13/2023. The facility's Policy on restraint and Abuse was reviewed. A facility-wide in-service on restraint and alternatives to restraint was conducted on 03/09/2023-03/14/2024-100% of staff was in-serviced. The audit tool Resident Restraint reviewed. Audits were performed for one year, four times a month. Results of audits dated from 03/10/2023 to 02/12/2024 reveal no concern. Results of audits were presented at Quality Assurance Performance Improvement meetings dated 04/27/2023, 07/27/2023, 10/30/2023, and 1/25/2024. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nursing/Designee monitoring of staff compliance with abuse/restraint prevention protocols. Interviews conducted on 10/19/2024 with staff (4 Certified Nursing Assistants, 3 Licensed Practical Nurses, 2 Registered Nurses, 1 Registered Supervisor, two housekeepers, 1 Security Guards, and 1 Social Worker) revealed staff was knowledgeable about the abuse and restraint policy. 10 NYCRR 415.4(a) (2-7)