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	07/17/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews conducted during an Abbreviated Survey (NY00373522), the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, mistreatment, or misappropriation of resident property were reported immediately, but not later that two (2) hours after the allegation is made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involved abuse and do not involve serious bodily injury, to the administrator of the facility and to other officials (including to the State Agency). This was evident for one (1) out of three (4) residents (Resident #2) sampled. Specifically, Resident #2 was observed sitting on the floor close to their bed with their rolling walker close by. Milk was spilled from an opened container that was in Resident #2's basket (attached to rolling walker) at approximately 4:25 PM on 02/22/2025. Resident #1 had no visible injuries. However, on 02/25/2025 at approximately 5:00 PM, Resident #2 was observed with grimacing while they were attempting to stand. An x-ray result dated 02/26/2025 documented an acute fracture of the left femur with osteoporosis. Resident #2 was transferred to the hospital on [DATE] at 11:20 PM where they subsequently underwent a closed reduction internal fixation (surgical procedure where metal implants hold broken bones together as they heal) surgical procedure of the left hip. The facility did not report the fracture (injury of unknown origin) within 2-hours to the New York State Department of Health. The facility became aware of the fracture on 02/26/2025 (unsure of time) and reported the fracture to the Department of Health on 02/27/2025 at 1:31 PM. The findings are: The facility's policy and procedure entitled Abuse Prevention, last reviewed 12/2018, documents that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than 2 hours after the allegation is made. If the events that cause the allegation do not involve abuse and do not result serious bodily injury, to the administrator of the facility and other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term facilities) in accordance with State law through established procedures. The facility's Policy and Procedure titled Resident Accident and Incident with a review date of 10/20/2024 documented that it is the policy of this facility to assess all residents of the facility on admission, readmission. Whenever a change of condition occurs, to identify risk factors, and to implement appropriate interventions to decrease or to prevent incidents/accidents. All Accident and Incident Reports will have supportive documentation in the nursing progress notes that describes the occurrences, the vital signs, full physical assessment, interventions, and notification of the family/designated representative and the physician. For all accidents, the resident will be carried on the report for 72 hours. The Charge Nurse will revise the Certified Nursing Accountability Record, including pertinent preventative measures, as needed. The Comprehensive Care Plan will be reviewed and revised as needed to reflect the occurrence and preventative measures. Resident #2 was admitted to the facility with diagnoses including Alzheimer's Dementia, Cancer, and Diabetes Mellitus. The Minimum Data Set, an assessment tool, dated 11/02/2024 documented Resident #2 had severely impaired cognition. The facility's Summary of Investigation dated 02/26/2025 documented on 02/22/2025 at 4:25 PM Resident #2 had an unwitnessed fall. Resident #2 was observed sitting on the floor near their bed with their rolling walker nearby and an opened container of milk spilling as it was leaning on its side in Resident #2's basket. Resident #2 was noted with no injuries and denied of pain. Range of motion was performed to both upper and lower extremities with no pain observed. On 02/25/2025 at 11: 17 PM Resident #2 was observed with grimacing when they attempted to ambulate. On 02/26/2025 at 4:55 PM, the (x-ray) result showed a hairline fracture of the proximal left femur with osteoporosis. Resident #2 was sent to the hospital on [DATE] at 6:00 PM. The facility investigation concluded that abuse, neglect, or mistreatment did not occur. Resident #2's bed was in a low position, and they were wearing nonskid socks. The floor prior to the incident was clean and dry and without clutter. A radiology report dated 02/26/2025 at 4:55 PM documented that an x-ray was completed of Resident #2' bilateral hip. The x-ray results showed an acute fracture of the left femur with osteoporosis. The right hip had no fracture. Osteophyte (bone spur) formation. During a telephone interview on 06/17/2025 at 3:41 PM, the Assistant Director of Nursing stated that the Director of Nursing was not at the facility at the time of the incident and that they were responsible for reporting the fracture. The Assistant Director of Nursing stated the incident was not reported to the New York State Department of Health, because it was their understanding they were supposed to report within 24

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during an abbreviated survey (NY00370671 and NY00373522), the facility did not ensure that a resident received the necessary care and treatment in a timely manner and in accordance with professional standards of practices. This was evident in two (2) out of five (5) residents (Resident #1 and Residents #2) sampled. Specifically, 1.) on 01/30/2025 at 12 midnight Certified Nursing Assistant #1 observed Resident #1 at the sink in their room holding their right hand under the cold water. According to Certified Nursing Assistant #1, they observed Resident #1's right hand to be a little red but they did not report it to the nurse. At 4:30 AM on 01/30/2025, Certified Nursing Assistant #2 observed Resident #1 at the sink in their room holding their right hand under the cold water. Certified Nursing Assistant #2 stated that Resident #1's right was bloody, swollen, and red. Registered Nurse Supervisor #1 was notified, and Resident #1 was transferred to the hospital on [DATE] at 9:45 AM. The Emergency Department to Hosp-admission discharged summary dated 01/30/2025 documented that Resident #1 sustained an unwitnessed one percent, second degree superficial partial thickness burn due to putting their hand in hot water. Resident #1 was first observed at midnight with redness to their right hand, the charge nurse or nursing supervisor was not notified, and there were no interventions implemented. Additionally, Resident #1 was not transferred to the hospital timely. 2.) Registered Nurse Supervisor #2 stated that while they were conducting rounds on 02/25/2025 at 9:00 AM they observed Resident #2 with facial grimacing; they notified Medical Doctor #1 after morning report ended (unsure of time), and Medical Doctor #1 ordered a STAT x-ray on 02/25/2025 (unsure of time). The Physician's Order dated 02/25/2025 revealed that the x-ray was ordered at 3:02 PM. The diagnostic x-ray results revealed that the x-ray was done on 02/26/2025 and the diagnostic medical doctor signed off on the results at 4:57 PM. The x-ray results revealed that Resident #1 sustained an acute fracture of the left femur in normal alignment with osteoporosis. The facility received the x-ray results at 4:55 PM on 02/26/2025. There was no documented evidence to support that a STAT x-ray was ordered. Resident #2 was transferred to the hospital on [DATE] at 6:00 PM where they subsequently underwent a closed reduction internal fixation (surgical procedure used to treat bone fractures). The findings include: The facility's Policy and Procedure titled Resident Accident and Incident with a review date of 10/20/2024 documented that it is the policy of this facility to assess all residents of the facility on admission, readmission. Whenever a change of condition occurs, to identify risk factors, and to implement appropriate interventions to decrease or to prevent incidents/accidents. All Accident and Incident Reports will have supportive documentation in the nursing progress notes that describes the occurrences, the vital signs, full physical assessment, interventions, and notification of the family/designated representative and the physician. For all accidents, the resident will be carried on the report for 72 hours. The Charge Nurse will revise the Certified Nursing Accountability Record, including pertinent preventative measures, as needed. The Comprehensive Care Plan will be reviewed and revised as needed to reflect the occurrence and preventative measures. The facility's Policy and Procedure titled STAT X-rays with a revised date of 09/18/2024 documented to ensure timely and appropriate ordering, communication, and completion of STAT X-rays for residents, ensuring promptly diagnosis and treatment while minimizing risk to resident health and safety. The nurse must notify the radiology vendor via telephone of the need for a STAT X-ray. The radiology vendor must provide the nurse a STAT confirmation number. The time of order, notification, and vendor acknowledged must be documented. The facility's Policy and Procedure titled [NAME] in Condition with a review date of 08/24/2024 documented the facility promptly will notifies the resident's attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. Resident #1 was admitted to the facility with diagnoses including Major Depressive disorder, Diabetes Mellitus, non-Alzheimer Disease. The Minimum Data Set, an assessment tool, dated 11/02/2024 documented that Resident #1 had moderately impaired cognition The facility's Summary of Investigation dated 01/31/2025 documented that on 01/30/2025 at 4:30 AM, Resident #1 was observed running their right hand under cold water in the sink in their room. Upon inspection of the right hand, Certified Nursing Assistant #2 observed Resident #2's right hand to be red and swollen. Certified Nursing Assistant #2 called out to Licensed Practical Nurse #1 on the unit to report their finding. Upon the assessment by Registered Nurse Supervisor #1, Resident #1's right hand was observed to be red, swollen, bleeding, and the skin peeling. The area was cleansed, and dressing was provided to the right hand. Resident #1 was transfer to the hospital for treatment