STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335079	A. Building B. Wing	07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gold Crest Care Center	2316 Bruner Avenue Bronx, NY 10469

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. 39365 Based on record review and interviews conducted during an abbreviated survey (Case # NY00314017) the facility did not ensure that all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made, to the New York State Department of Health. This was evident for 1 out of 7 residents (Resident #6) sampled for abuse. Specifically, on 03/28/2023, Resident #6's adult child called Licensed Practical Nurse #2 and stated that Certified Nursing Assistant #1 was rough when providing personal care. The allegation of rough handling of Resident #6 was not reported to the New York State Department of Health. The Findings are: The facility's Policy and Procedure titled Abuse Prohibition: Reporting and Prevention reviewed/revised on 04/2024, documented all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. Resident #6 was admitted to the facility with diagnoses including Liver Cirrhosis/Ascites (Liver problems), Thrombocytopenia (bleeding problems), and Dementia (memory loss). A Minimum Data Set (a resident assessment tool) dated 01/17/2023, documented Resident #6 had moderately impaired cognition. A Facility Internal Investigation dated 03/28/2023, documented that on 03/28/2023 at around 6:25 PM, Resident #6's adult child called Licensed Practical Nurse #2 and stated that their parent called them and complained that the Certified Nursing Assistant #1 was rough during personal care. Licensed Practical Nurse #1 notified the Director of Nursing and Administrator. The facility investigated the incident and concluded that abuse did not occur. There was no documented evidence the facility reported an allegation of rough handling during care to the New York State Department of Health. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/26/2024 at 1:28 pm, the Director of Nursing stated they and the Administrator were responsible for investigating the incidents, reporting to the New York State Department of Health and to local law enforcement. The Director of Nursing stated they did not report Resident #6's allegation of rough handling during care to the New York State Department of Health because they felt Resident #6 misunderstood Certified Nurse Assistant #1 action when they attempted to prevent Resident #6 from falling on 03/23/2023. During an interview on 07/23/24 at 3:24, the Administrator stated that the Director of Nursing is responsible for the investigation of the incidents, and the Director of Nursing or Administrator is responsible for reporting to the Department of Health or other authorities. The Administrator stated that the allegation of rough handling constitutes abuse, but the case was not reported to the Department of Health because they were able to rule out abuse within 2 hours, and it was unsubstantiated. 10 NYCRR 415.4(b)(2)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39365 Based on record review and interviews conducted during an abbreviated survey (Case # NY00348463) on 07/22/2024-07/23/2024, the facility failed to notify Justice Involved Residents of their transfer or discharge and the reason for the move in writing. Additionally, the facility did not send a copy of the transfer or discharge notice to the Office of New York State Long Term Care Ombudsman. This was evident for 4 out of 5 Justice Involved Residents (Justice Involved Resident #1, Justice Involved Resident #2, Justice Involved Resident #3, and Justice Involved Resident #5). Specifically, Justice Involved Resident #1, #2, #3, and #5 were discharged from the facility, there was no documented evidence that a discharge or transfer notice was provided to them. The facility did not notify the New York State Long Term Care Ombudsman office that Justice Involved Residents #1, #2, #3, and #5 were discharged from the facility. The Findings are: The Facility's Policy and Procedures, entitled Change in Condition, revised date 04/2024, documented that the facility must immediately inform the resident, consult with the resident's physician, and, if known, notify the resident's legal representative or an interested family member when a decision is made to transfer or discharge the resident from the facility. The Facility's Policy and Procedures Discharge Process, revised date 04/2024, documented the purpose to implement an effective discharge planning process that focuses on the resident's discharge goals, preparing the resident to be active partners and effectively transitioning them to post-discharge care, and reducing factors to prevent readmissions. Justice Involved Resident #1 was admitted on [DATE], to the facility with a diagnosis of Cord Compression (Spine Problem), Hemiplegia (left side weakness), and Cerebral infarction. The Minimum Data Set 3.0 assessment (an assessment tool) dated 11/14/2022, documented that Justice Involved Resident #1 had intact cognition. A Care Plan for Return to Community Referral initiated on 05/31/2022, target date 02/01/2023, documented that Justice Involved Resident #1 to be discharged from the facility. The interventions include arranging for a discharge planning conference. A Physician's order dated 02/02/2023, documented a discharge order to the custody of Bureau of Prisons guards and the medical transport team. A Physician's Discharge Summary dated 02/02/2023, documented Justice Involved Resident #1 with a Seizure (uncontrolled body movements), and Psychosis was stabilized and transferred to another state facility. A Review of Justice Involved Resident #1's medical record revealed no documented evidence that a Discharge or Transfer Notice was given in writing to Justice Involved Resident #1 or their legal representative. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Office of the New York State Long Term Care Ombudsman was not notified that Justice Involved Resident #1's was discharged . Justice Involved Resident #2 was admitted to the facility on [DATE], with diagnoses of Type 2 Diabetes Mellitus (high blood sugar), End Stage Renal Disease (urine problem), and Atherosclerotic Heart Disease (heart problems). The Minimum Data Set 3.0 Assessment (an assessment tool) dated 05/08/2023, documented that Justice Involved Resident #2 had intact cognition. A Care Plan for Return to Community initiated on 03/01/2022, documented return to the community with interventions that included considering the resident's and family's preferences for care. A Physician Discharge Summary dated 06/08/2023, documented Justice Involved Resident #2 with End Stage Renal Disease was stabilized and transferred to a federal facility. A Physician order dated 06/09/2023, documented an order to discharge Justice Involved Resident #2 to federal custody. A Review of Justice Involved Resident #2's medical record revealed no documented evidence that a Discharge or Transfer Notice was given to Justice Involved Resident #2 or to their legal representative. The New York State Long Term Care Ombudsman office was not notified that Justice Involved Resident #2's was discharged . Justice Involved Resident #3 was admitted to the facility on [DATE], with diagnoses of Peripheral Vascular Disease, Venous insufficiency (circulation problems), and Chronic Cellulitis to the left foot. The Minimum Data Set 3.0 assessment (an assessment tool) dated 09/28/2023, documented that Resident #3 had intact cognition. A Care Plan Return to Community Referral initiated on 03/10/2020 and updated on 11/19/2023, documented Justice Involved Resident #3 will be discharged to a federal correctional facility. The interventions included providing education to maintain safety. A Physician's Order dated 11/22/2023, documented Justice Involved Resident #3 was transferred by United States Marshall to another Nursing Home. A Physician Discharge Summary dated 11/25/2023, documented Justice Involved Resident #3 was in the facility for chronic medical issues, including Obesity, and was transferred to another Skilled Nursing Facility for further care. A Review of Justice Involved Resident #3's medical record reveals no documented evidence that a Discharge or Transfer Notice was given to Justice Involved Resident #3 or their legal representative. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The New York State Long Term Care Ombudsman office was not notified that Justice Involved Resident #3 was discharged from the facility. Justice Involved Resident #5 was admitted to the facility on [DATE], with diagnoses of Right Above Knee Amputation(leg removed), Infection of Amputation Stump, and Atrial Fibrillation (heart problems). A Care Plan Return to Community Referral was initiated on 07/28/2023, and updated on 01/16/2024. Resident #5 was scheduled to be discharged from the facility. The interventions included arranging a discharge planning conference. A Physician's Order dated 03/20/2024, documented an order to transfer Resident #5 to a skilled nursing facility (name redacted) under the custody of the United States Marshall. A Physician Discharge Summary dated 03/25/2024, documented Resident #5 with Above- Knee Amputation, Atrial Fibrillation was treated, and the Gait (balance) was stabilized. Justice Involved Resident #5 was stable to be transferred to another skilled nursing facility. A Review of Resident #5's medical record revealed no documented evidence that a Discharge or Transfer Notice was given to Resident #5 or their legal representative. The Office of the New York State Long Term Care Ombudsman was not notified of Resident #5's discharge. During an interview on 07/22/2024 at 4:20 PM, the Director of Social Service stated when a resident is going to the hospital, the admission department provides them a written Notice of Transfer/Discharge with a bed hold policy. The Director of Social Service stated if the resident goes to another facility, the Social Worker provides a notice of Transfer/Discharge before they leave. The Director of Social Service stated that they did not give a Notice of Discharge/Transfer to Justice-Involved Residents when they were transferred to other facilities or hospitals or if they went back to custody. The Director of Social Service stated that most of the time it last- minute discharge that is initiated by the doctor from the Bureau of Prison, and facility staff was not allowed to tell Justice-Involved Residents where and when they are discharged . The Director of Social Service further stated they did not notify the Ombudsman when Justice-Involved Residents were discharged from the facility. The Director of Social Service also stated that they do not notify the Ombudsman's office of discharge or transfers unless 30 days' notice is given. During an interview on 07/23/2024 at 12:11 PM, the Admission Director stated they notify the Ombudsman's office only when residents go to the hospital because of the bed hold policy. The Admission Director stated they do not notify the Ombudsman when residents are discharged to the community or to other facilities. During an interview on 07/23/2024 at 2:47 PM, the Administrator stated Social Workers are responsible for providing Notices of Discharge or Transfer to all residents. The Administrator stated that a Notice of Discharge or Transfer was not provided to Justice Involved Residents #1, #2, #3, and #5, due to security reasons and short notice from the Security Guards. The Administrator stated the Ombudsman's office is notified when residents are transferred to the hospital or if there are issues with the 30 days' notice. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10 NYCRR 415.3(h)(1)(iii)(a-c)