

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 11/20/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER Henry J Carter Skilled Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 1752 Park Ave Manhattan, NY 10035	
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 - 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. (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 0689 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 during an abbreviated survey (NY00374171), the facility did not ensure that each resident received adequate supervision to prevent an elopement. This was evident for one (1) out of three (3) residents (Resident #2) sampled for elopement. Specifically, a nursing note, by Registered Nurse #1, dated 03/02/2025 at 6:14 PM documented that Resident #2's adult child visited at around 3:00 PM and reported Resident #2 was not in their room. The Hospital Police and staff searched the building and Resident #2 was not found. The facility video surveillance footage dated 03/02/2025 showed Resident #2, who had a tracheostomy tube and was at high risk for elopement, exited the facility at 1:24 PM undetected by staff. The Certified Nursing Assistant Task sheet for March 2025 showed, under purposeful rounding conducted every two (2) hours, Resident #2 was last monitored at 6:00 AM on 03/02/2025 as indicated by staff's initial. An addendum on the Intake Information sheet dated 03/07/2025, documented that Resident #2's adult child reported that Resident #2 was found unresponsive by New York City Housing Authority in the hallway of a building at approximately 10:52 AM on 03/05/2025. Emergency Medical Service was called and pronounced the resident dead. The Findings are: The Elopement and Wandering policy dated 02/27/2024 documented the purpose of the policy is to prevent occurrences of residents leaving the facility undetected. The Wandering/Elopement Prevention/Rounding Every 2-Hours policy dated 03/03/2025 documented the purpose of the policy is to provide a safe environment for residents who are identified at risk of wandering or elopement, and to prevent injury and leaving the facility undetected. An undated Post Duties and Responsibilities documented of First Floor - Main Lobby. According to this undated document, personnel assigned: to verify that patients who are leaving the facility have a proper pass signed by the Head Nurse or Physician. Registered all patients and residents exiting and entering the facility. Register all visitors in the Visitor Management System, issuing visitor badges to authorized visitors. Register residents presenting a valid pass in the Resident Pass Log Computer System. Notification to resident ward (unit) when a resident attempt or leaves the facility without a valid pass, or appropriate color arm band. Detained any patient or resident attempting to depart the facility who has not been identified by nursing as not having decisional capacity to make judgments in his/her own best interests. Retrieve and scan visitor's badge. Resident #2 was admitted to the facility with diagnoses including history of elopement, history of Asthma, Alcohol and Poly Substance Abuse, and Respiratory Failure. The Minimum Data Set (a resident assessment tool) dated 03/02/2025 documented that Resident #2's has a Brief Interview for Mental Status and scored 15 denoting intact cognition. Resident #2 was independent with most activities of daily living. An Elopement Risk Assessment form dated 02/08/2025 showed that Resident #2 was assessed for elopement and scored two (2) denoting risk for elopement. According to this form, any score above one (1) indicates risk for elopement. A Risk for Wandering/Elopement Care Plan with revision date of 11/20/2024, Aero Scout applied to left wrist and weekly restraint rounds. The interventions documented to encourage Resident #2 in purposeful activity, identify if there was a certain time of day wandering/elopement attempted, schedule time for regular walks and appropriate activity. There was no documented evidence of monitoring on the elopement care plan. A Physician's readmission Order dated 03/01/2025 documented application of the Aero Scout Bracelet. The Certified Nursing Assistant Task sheet for March 2025 showed under purposeful rounding, Resident #2 was last monitored at 6:00 AM on 03/02/2025. A nursing note, by Registered Nurse #1, dated 03/02/2025 at 6:14 PM documented that Resident #2's adult child visited at around 3:00 PM and reported Resident #2 was not in their room. The Hospital Police and staff searched the building and Resident #2 was not found. Resident #2 removed the Aero Scout device from their left wrist, and it was found on their bed. Cameras' review showed Resident #2 left the building at 1:24 PM wearing a long winter coat, a furry bucket hat, and was carrying a black bag. Resident #2's adult child reported that the resident verbalized to them that they wanted to go home. New York Police Department was notified. The facility's Department of Nursing Quality Review Report dated 03/03/2025 documented Resident #2 has had several discharges and readmission and was recently transferred to the hospital on [DATE]. While Resident #2 was in the hospital the resident stole a patient wallet and credit cards. The stolen items were found in Resident #2's possession and the resident were arrested and charged with Felony/Grand Larceny. Resident #2 was readmitted to the facility on [DATE] and an elopement bracelet was applied to their left wrist on 03/02/2025 at 9:00 AM by Hospital Police Officer (#1). Resident #2 was observed by staff eating their lunch in their room at 12:30 PM on 03/02/2025. Resident		

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)		

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review conducted during an abbreviated survey (NY00380551), the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and in accordance with the residents' goals and preferences. This was evident for one (1) of three (3) residents (Resident #1) sampled for respiratory care and treatment. Specifically, on [DATE] at 4:01 PM, Resident #1 returned from the certified dialysis unit located within the facility. Resident #1 was on a portable ventilator accompanied by Escort #1 and Respiratory Therapist #1. Upon return to Resident #1's room Respiratory Therapist #1 disconnected the portable ventilator and connected Resident #1 to the bedside ventilator but did not take the bedside ventilator off standby mode or check that Resident #1 was being ventilated (receiving oxygen). Additionally, Registered Nurse #1 did not assess or check that Resident #1's ventilator was removed from standby mode, and that they were being ventilated. As a result, Resident #1 did not receive mechanical ventilation from the ventilator for 29 minutes and became unresponsive, requiring cardiopulmonary resuscitation to be initiated. Resident #1 was revived and then hospitalized where they ultimately expired. These circumstances resulted in actual harm to Resident #1 and the potential for serious harm to the health and safety of all thirty-nine (39) ventilator dependent residents in the facility, which was Immediate Jeopardy. The findings are: A review of the facility's policy on Respiratory Care Service-In House Transport of Residents on Oxygen/Ventilator dated [DATE] documented, it is the policy of the Respiratory Care Service to establish guidelines in order to ensure efficient and safe resident transports. Resident #1 was admitted to the facility with diagnosis including renal insufficiency (a condition where the kidneys are not functioning properly), cerebrovascular accident (a medical emergency that occurs when blood flow to the brain is disrupted, causing brain cells to die), and respiratory failure (occurs when the lungs cannot exchange oxygen and carbon dioxide effectively). A review of the Minimum Data Set (an assessment tool) dated [DATE], documented that Resident #1's cognition was severely impaired. A review of the Comprehensive Care Plan for Tracheostomy dated [DATE] documented interventions to ensure that tracheostomy ties are always secured and monitor/document Resident #1 for restlessness, agitation, confusion, increased and decreased heart rate. A nursing note dated [DATE] by Registered Nurse Supervisor #3 (for 8:00 AM-4:00 PM shift) at 7:44 PM documented Resident #1, connected to a portable ventilator, arrived from dialysis onto the unit at 4:01 PM via stretcher with Escort #1 and Respiratory Therapist #1. At around 4:30 PM, Resident #1 was found unresponsive by Certified Nursing Assistants (#1 & #2). Registered Nurse #2 and Respiratory Therapist #1 were notified, and cardiopulmonary resuscitation was initiated. Code Blue was called at 4:34 PM and team arrived at 4:40 PM and compression and bagging (using a bag-valve-mask device to deliver breaths to a resident, often in conjunction with chest compressions) continued until the Emergency Medical Team arrived and took over. Resident #1 was revived and taken to the hospital at 5:10 PM. The facility's investigation dated [DATE] documented on [DATE] at 4:01 PM, Resident #1 returned from the certified dialysis unit located within the facility accompanied by Escort #1 and Respiratory Therapist #1. According to the camera review, Escort #1 reported to Registered Nurse #1 that Resident #1 had returned to the unit. At approximately 4:30 PM, Certified Nursing Assistants #1 and #2 were monitoring residents and observed Resident #1 was unresponsive. Registered Nurse #2 and Respiratory Therapist #1 were notified immediately, and cardiopulmonary resuscitation was initiated and continued until Resident #1 was revived and sent to the hospital for further evaluation at 5:10 PM. The facility concluded that Respiratory Therapist #1 and Registered Nurse's #1 and #3 did not follow the process of checking on Resident #1 upon receiving endorsement from Escort #1. The Registered Nurses were responsible for checking Resident #1's vitals, placing them back to bed and connecting them to the ventilator. A review of the unit hallway surveillance video recording dated [DATE] showed at 4:00 PM, Resident #1 was on a stretcher and being pushed by Respiratory Therapist #1 and Escort #1 into their room. Escort #1 exited the room seconds after entering the room and Respiratory Therapist #1 exited the room at 4:04 PM. Certified Nursing Assistants #1 and #2 appeared in the hallway at 4:22 PM and entered Resident #1's room at 4:25 PM. Between 4:25 PM and 4:30 PM, the Certified Nursing Assistants are seen exiting and reentering the room. At 4:30 PM, Registered Nurse #2 entered Resident #1's room. At 4:31 PM, Respiratory Therapist #1 entered the room. Additional responders observed entering the room at 4:32 PM. During an interview on		