

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/09/2025
NAME OF PROVIDER OR SUPPLIER Isabella Geriatric Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 515 Audubon Avenue New York, NY 10040	

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during the Abbreviated Survey (Complaint 2588679), the facility did not ensure that all alleged violations involving abuse, neglect, including injuries of unknown source were reported immediately, but not later than 2 hours after the allegation was made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the New York State Department of Health. This was evident for one (1) (Resident #2) of six (6) residents reviewed for accidents. Specifically, Resident #2 had an unwitnessed fall on 07/16/2025 resulting to a laceration to the left eyebrow and eventually was found to have an acute fracture in the humeral neck that was not reported to the New York State Department of Health. The findings include: The facility policy and procedure titled Abuse Prohibition-Prevention and Reporting which was last revised in March 2025 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 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to New York State Department of Health. Resident #2 was admitted with diagnoses that included Dementia and Breast Cancer. The Minimum Data Set assessment dated [DATE] documented Resident #2's cognition as severely impaired and that resident never/rarely made decisions. The resident required substantial assistance with bed mobility and transfers. A nurse's progress note dated 07/16/2025 at 11:45 PM documented that Resident #2 was observed lying on the floor on their left side against the closet. Resident #2 sustained a 1.5-centimeter laceration on the left eyelid that was bleeding. The physician was notified, and resident was sent to the emergency room for evaluation. A nurse's progress note dated 07/17/2025 at 4:55 PM documented that Resident #2 returned from the emergency room with recommendation to keep the wound on the left eyebrow dry and clean. The note documented that computed tomography scans and x-rays were completed in the emergency room, but no reports were sent with the resident. A nurse's progress note dated 07/20/2025 at 1:44 PM documented that Resident #2 complained of left shoulder pain. X-ray of the left shoulder revealed acute fracture of the humeral neck. There was also decreased bony mineralization suggestive of osteopenia or osteoporosis. The resident was transferred to the emergency room. The undated document titled Root Cause Analysis documented that at about 9:45 PM on 07/16/2025, the staff reported that Resident #2 was found on the floor, with skin laceration on the left eyelid. The resident was transferred to the emergency room and returned on 07/17/2025 with negative scan and x-ray results. On 07/19/2025, the next of kin reported that the resident was guarding their arm. The x-ray report showed acute humeral neck fracture. The facility concluded that it appeared that resident got up from the bed and fell. Resident has impaired vision secondary to the fall. Resident also has bony demineralization with arthritic changes which could have caused the fracture hence non-reporting to the Department of Health. On 10/22/2025 at 11:41 AM, the Director of Nursing was interviewed and stated that they are responsible for reporting allegations to the New York State Department of Health. They stated that Resident #2 had an unwitnessed fall and that the left arm fracture was identified two (2) days after the said fall. The Director of Nursing stated they correlated the fracture from the fall, which was why the incident, and the injury was not reported to the New York State Department of Health. On 10/22/2025 at 12:26 PM, the Administrator was interviewed and stated that Resident #2's fall and fracture were discussed during the morning report. It was not reported because they knew how the fall happened, and that the fracture was correlated with the fall. The Administrator stated, they and Director of nursing are responsible for reporting incidents to the New York State Department of Health. 10 NYCRR 415.4(b)(2)</p>		