

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/09/2024
NAME OF PROVIDER OR SUPPLIER  Sapphire Center for Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  35 15 Parsons Blvd Flushing, NY 11354	

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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44864</b></p> <p>Based on observation, record review, and interviews conducted during the Recertification and Abbreviated (NY00340290) survey from 4/29/2024 to 5/9/2024, the facility did not ensure a resident was free from physical abuse. This was evident for 1 (Resident #77) of 3 residents reviewed for abuse out of 39 total sampled residents. Specifically, surveillance camera footage revealed on 4/23/2024 at 12:06 PM, Certified Nursing Assistant #1 struck Resident #77 causing the resident to fall backwards onto the floor. Certified Nursing Assistant #1 then grabbed Resident #77 by their wrists, lifted the resident off the floor, and pulled them to their room. Registered Nurse #1 and Certified Nursing Assistant #2 witnessed the incident and did not intervene. Subsequently, Resident #77 was diagnosed with a left wrist fracture because of the incident. This resulted in Substandard Quality of Care that was Immediate Jeopardy that resulted in serious injury for Resident #77 with the likelihood of a serious adverse outcome occurring to other residents on the unit.</p> <p>The findings are:</p> <p>The facility policy titled Abuse Prevention/Prohibition dated 11/2022 stated that all residents will be screened for potential abuse, an investigation will be conducted, the Administrator is responsible for completing the investigation report, any person having reasonable cause to believe that an older adult is in need of protective services may report such information to the local provider, and all interventions will be documented in the resident's medical record.</p> <p>Resident #77 had diagnoses of dementia and osteoarthritis (degeneration of joint cartilage and underlying bone.)</p> <p>The Minimum Data Set 3.0, a resident assessment instrument, dated 1/14/2024 documented Resident #77 was severely cognitively impaired, did not display inappropriate behavior, ambulated with supervision or touch assistance, and required assistance when using a wheelchair.</p> <p>A Comprehensive Care Plan related to potential for abuse and neglect initiated 1/7/2024 and last reviewed 4/24/2024, documented Resident #77 was at risk for abuse due to their dementia diagnosis and one-to-one interaction would be provided until the resident was calm.</p> <p>(continued on next page)</p>

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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility's video surveillance dated 4/23/2024 at 12:05 PM revealed Resident #77 was in the hallway on their unit and attempted to walk into their room. Certified Nursing Assistant #1 exited the room and stood in between Resident #77 and the entrance to their room. Resident #77 slapped Certified Nursing Assistant #1. Certified Nursing Assistant #1 then struck Resident #77 causing the resident to fall backwards and land on the floor in a supine position (flat on their back). Certified Nursing Assistant #1 grabbed Resident #77's wrists, lifted the resident to their feet, and pulled the resident into their room. Registered Nurse #1 and Certified Nursing Assistant #2 were seated at the nursing station directly in front of Resident #77 and Certified Nursing Assistant #1 when the incident occurred. Registered Nurse #1 and Certified Nursing Assistant #2 did not intervene during the incident.</p> <p>The facility's Accident/Incident Report on 4/23/2024 documented Resident #77 was pacing in the hallway on their unit, hit Certified Nursing Assistant #1, and then fell to the floor causing a left wrist fracture.</p> <p>The Nursing Note written by Registered Nurse #1 was dated 4/23/2024 at 12:08 PM and documented Resident #77 became physically aggressive toward staff, slapped a Certified Nursing Assistant, fell to the floor, and reported left wrist pain. Resident #77's left wrist was swollen, the Medical Doctor was informed, and an x-ray was done. At 10:29 PM, a Registered Nurse on the evening shift documented Resident #77's next of kin requested the resident be sent to the hospital for evaluation and Resident #77 was transferred to the hospital.</p> <p>A Nursing Note dated 4/24/2024 documented Resident #77 returned from the hospital with a cast to their left wrist due to left wrist fracture.</p> <p>The Summary of Investigation completed by the Director of Nursing, dated 4/25/2024, documented video surveillance footage and staff statements were reviewed. Registered Nurse #1 failed to report Resident #77's incident accurately, falsified documentation, and misled the investigation. Abuse of Resident #77 did occur on 4/23/2024.</p> <p>A review of facility inservice and training records from 1/2023 to 4/2024, revealed no documented evidence that Certified Nursing Assistant #1 received training on the abuse policy and procedures in 2023 or 2024. A review of staffing sheets dated 4/23/2024 and 4/24/2024, revealed that Certified Nursing Assistant #1 was still scheduled and continued to work on the unit with residents after the incident involving Resident #77.</p> <p>On 4/29/2024 at 10:30 AM and 5/06/2024 at 10:28 AM, Certified Nursing Assistant #2 was interviewed and stated they were assigned to Resident #77 on 4/23/2024. They heard a loud noise while sitting at the nursing station and saw Certified Nursing Assistant #1 grab Resident #77 off the floor and bring the resident back to their room. Certified Nursing Assistant #2 stated they were confused about what they saw and did not know how to react. Registered Nurse #1 went to Resident #77's room to follow up after Certified Nursing Assistant #1 brought the resident there.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 4/29/2024 at 10:52 AM, Registered Nurse #2 was interviewed and stated they were the supervisor for the building on 4/23/2024 at the time of the incident involving Resident #77 and Certified Nursing Assistant #1. Registered Nurse #1 reported to them that Resident #77 fell , and they both viewed the video at 1:40 PM on 4/23/2024. Registered Nurse #2 stated they could not determine what transpired from watching the surveillance footage and reported the incident to the Inservice Coordinator because Registered Nurse #2 was busy.</p> <p>On 4/29/2024 at 12:01 PM, Registered Nurse #1 was interviewed and stated they were the charge nurse on Resident #77's unit on 4/23/2024. They were seated at the nurse's station, heard a loud slapping sound, and looked up to see Resident #77 lying on the floor. Registered Nurse #1 stated they were unable to determine what transpired in front of them, so they reviewed the surveillance footage. They stated Certified Nursing Assistant #1 provided their statement of occurrence to them and reported that Resident #77 fell after slapping Certified Nursing Assistant #1. Registered Nurse #1 stated after reviewing the surveillance footage, they believed Certified Nursing Assistant #1 provided assistance to assisted Resident #77 when lifting them off the floor and taking them to their room. Registered Nurse #1 informed the supervisor, Registered Nurse #2, of the fall incident so that another Registered Nurse could provide input into the events that transpired on surveillance footage.</p> <p>On 4/29/2024 at 1:17 PM, an interview was conducted with the Medical Director who stated they were informed on 4/25/2024 of Resident #77's incident on 4/23/2024, saw the surveillance footage with the Administrator, and advised the Director of Nursing and the Administrator to report the incident to the New York State Department of Health.</p> <p>On 4/29/2024 at 3:10 PM, the Administrator was interviewed and stated they were made aware of Resident #77's incident on 4/25/2024, reviewed the surveillance footage, and contacted the New York City Police Department to report Certified Nursing Assistant #1 was involved in an abuse incident. The Administrator was unable to provide an explanation for staff members' inability to identify and adequately address incidents of abuse. The Administrator stated the staff did receive inservices and education regarding abuse prior to the incident on 4/23/2024; however, the staff needed more in-service and training regarding abuse prevention and reporting.</p> <p>On 5/09/2024 at 2:59 PM, the Director of Nursing was interviewed and stated they became aware of an incident involving Resident #77 on 4/24/2024. Registered Nurse #1 reported the resident hit Certified Nursing Assistant #1. The Director of Nursing saw the surveillance footage at 5:00 PM on 4/24/2024 and determined Certified Nursing Assistant #1 struck Resident #77 and picked the resident up off the floor by themselves. The Administrator was not in the facility at the time and the Director of Nursing informed the Administrator the next day on 4/25/2024. Certified Nursing Assistant #1 and Registered Nurse #1 were terminated as a result of the Director of Nursing's investigation. Registered Nurse #2 should have informed the Director of Nursing if they were unsure of the events that took place on the surveillance footage and was suspended for 1 day due to their failure to inform the Director of Nursing after reviewing surveillance footage related to Resident #77.</p> <p>Multiple attempts were made to contact Certified Nursing Assistant #1, who was no longer employed at the facility. Certified Nursing Assistant #1 did not return calls for an interview.</p> <p>On 4/29/2024 at 8:22 PM, Immediate Jeopardy was identified and declared. The facility's Administrator and the Director of Nursing were notified.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 5/03/2024 at 2:00 PM, a removal plan was implemented, and Immediate Jeopardy was lifted based on the following corrective actions taken by the facility:</p> <ul style="list-style-type: none"> <li>-Termination Letter documents Certified Nursing Assistant #1 was terminated dated 4/26/2024 and letter was sent to Certified Nursing Assistant #1 dated 5/1/2024.</li> <li>-Termination letter documents dated 4/29/2024 for Registered Nurse #1 for failing to accurately report and document instance of abuse, not intervening on behalf of the resident and improperly completing the Accident and Incident Report related to abuse, mistreatment, and neglect.</li> <li>-Resident #77's care plan was updated on 4/24/2024, and resident was seen by a psychiatrist on 5/02/2024, who documented resident does not appear to be suffering from emotional stress from the incident and will be followed up as necessary.</li> <li>- The facility's investigation regarding abuse allegation was completed on 4/25/2024 by the Director of Nursing.</li> <li>-The policy on Behavior and Dementia Care and Abuse prevention were reviewed 1/2022, 1/2023, 4/2024.</li> <li>-The following documents were received and reviewed. Social worker care plan for abuse prevention was updated, Medical Doctor assessment and evaluation dated 4/24/2024; Registered Nurse assessment dated [DATE].</li> <li>- Lesson plans on Abuse, neglect and mistreatment, Behavioral Health, Alzheimer's Disease and Dementia and Incident reporting, with attendance and sign-in sheets were reviewed and documented that 76% (182 of 239) of all staff in serviced, including Certified Nursing Assistants= 80%, Licensed Practical Nurses= 75%, Registered Nurses= 65%, Recreation = 81%, and Social Services= 100%.</li> <li>-Multiple observations were conducted on Resident #77 from 4/24/2024 - 5/09/2024 and no concerns noted.</li> <li>-Team observation on staff while performing resident care did not reveal any sign of abuse, neglect, or mistreatment.</li> </ul> <p>Based on observation, interview and record review conducted on 5/03/2024, the facility fully implemented the Immediate Jeopardy Removal Plan, and the Immediate Jeopardy was removed as of 5/03/2024 at 2:00 PM.</p> <p>10 NYCRR 415.4(b)(1)(i)</p>

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44864</p> <p>Based on record review and interviews conducted during the Recertification and Abbreviated (NY00340290) Survey from 4/29/2024 to 5/9/2024, the facility did not ensure that all alleged violations involving abuse were immediately reported to the New York State Department of Health, but not later than 2 hours after the allegation was made. This was evident for 5 (Resident #77, Resident #32, Resident #111, Resident #79, and Resident #91) of 39 total sampled residents. Specifically, 1) an allegation of staff-to-resident abuse involving Certified Nursing Assistant #1 and Resident #77 occurred on 4/23/2024 and was not reported to the New York State Department of Health until 4/25/2024, 2) the facility did not report to the New York State Department of Health when Resident #32 was found on the floor and determined to have a left wrist fracture, 3) Resident #111 sustained swollen wrist which was an injury of unknown origin, was not reported New York State Department of Health within 2 hours of occurrence. 4) the facility did not report to the New York State Department of Health when Resident #79 was found on the floor with a laceration to the forehead that required an evaluation at the hospital, and 5) Resident #91 was hit in the arm by another resident and the facility did not report the allegation of resident-to-resident abuse to the New York State Department of Health.</p> <p>This resulted in Substandard Quality of Care that was Immediate Jeopardy which resulted in serious injury for Resident #77 with the likelihood of a serious adverse outcome of occurring to other residents on the unit.</p> <p>The findings include but are not limited to:</p> <p>The facility policy titled Reporting Suspected Crimes under the Federal Elder Justice Act dated 10/2022 states that covered individuals must report suspicion of a crime to the New York State Department of Health and local law enforcement immediately, but not later than 2 hours after forming suspicion if the events involved serious bodily injury. If the reportable event does not result in serious bodily injury, the covered individual must report the suspicion not later than 24 hours after forming suspicion.</p> <p>1) Resident #77 had diagnoses of dementia and osteoarthritis (degeneration of joint cartilage and underlying bone.)</p> <p>The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #77 was severely cognitively impaired, did not display inappropriate behavior, ambulated with supervision or touch assistance, and required assistance when using a wheelchair.</p> <p>A Comprehensive Care Plan related to potential for abuse and neglect initiated 1/7/2024 and last reviewed 4/24/2024 documented Resident #77 was at risk for abuse due to their dementia diagnosis and one-to-one interaction would be provided until the resident was calm.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility's video surveillance dated 4/23/2024 at 12:05 PM revealed Resident #77 was in the hallway on their unit and attempted to walk into their room. Certified Nursing Assistant #1 exited the room and stood in between Resident #77 and the entrance to their room. Resident #77 slapped Certified Nursing Assistant #1. Certified Nursing Assistant #1 then struck Resident #77 causing the resident to fall backwards and land on the floor in a supine position (flat on their back). Certified Nursing Assistant #1 grabbed Resident #77's wrists, lifted the resident to their feet, and pulled the resident into their room. Registered Nurse #1 and Certified Nursing Assistant #2 were seated at the nursing station directly in front of Resident #77 and Certified Nursing Assistant #1 when the incident occurred. Registered Nurse #1 and Certified Nursing Assistant #2 did not intervene during the incident.</p> <p>The facility's Accident/Incident Report initiated on 4/23/2024 documented Resident #77 was pacing in the hallway on their unit, hit Certified Nursing Assistant #1, and then fell to the floor causing a left wrist fracture.</p> <p>The Nursing Note written by Registered Nurse #1 was dated 4/23/2024 at 12:08 PM and documented Resident #77 became physically aggressive toward staff, slapped a Certified Nursing Assistant, fell to the floor, and reported left wrist pain. Resident #77's left wrist was swollen, the Medical Doctor was informed, and an x-ray was done. At 10:29 PM, a Registered Nurse on the evening shift documented Resident #77's next of kin requested the resident be sent to the hospital for evaluation and Resident #77 was transferred to the hospital.</p> <p>A Nursing Note dated 4/24/2024 documented Resident #77 returned from the hospital with a cast to their left wrist due to left wrist fracture.</p> <p>The Summary of Investigation completed by the Director of Nursing, dated 4/25/2024, documented video surveillance footage and staff statements were reviewed. Registered Nurse #1 failed to report Resident #77's incident accurately, falsified documentation, and misled the investigation. Abuse of Resident #77 did occur on 4/23/2024.</p> <p>There was no documented evidence the facility reported Resident #77's abuse incident to the New York State Department of Health within 2 hours of occurrence.</p> <p>On 4/29/2024 at 10:52 AM, Registered Nurse #2 was interviewed and stated they were the supervisor of the building on 4/23/2024 when Resident #77 was involved in an abuse incident and sustained a fractured left wrist. Registered Nurse #2 stated they could not determine what transpired from watching the surveillance footage and reported the incident to the Inservice Coordinator because Registered Nurse #2 was busy. Registered Nurse #2 stated they thought the Inservice Coordinator would inform the Director of Nursing.</p> <p>On 4/29/2024 at 12:01 PM, Registered Nurse #1 was interviewed and stated they were the charge nurse on the unit and was present and initiated the Accident/Incident investigation when Resident #77's incident occurred. Registered Nurse #1 stated they were unable to determine whether abuse occurred when they viewed the surveillance footage and informed the building supervisor, Registered Nurse #2, so they could view the surveillance footage.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 4/29/2024 at 3:10 PM, the Administrator was interviewed and stated they were made aware of Resident #77's incident on 4/25/2024, reviewed the surveillance footage, and contacted the New York City Police Department to report Certified Nursing Assistant #1 was involved in an abuse incident. The Administrator was unable to provide an explanation for staff members' inability to identify and adequately address incidents of abuse. The Administrator stated the staff needed more in-service and training regarding abuse prevention and reporting.</p> <p>On 5/09/2024 at 2:59 PM, the Director of Nursing was interviewed and said they initially were made aware of the incident on 4/24/2024 and they didn't rush to review the surveillance footage or report the incident because they didn't realize the incident was serious. The Director of Nursing reviewed the surveillance footage at 5:00 PM on 4/24/2024, observed the incident of abuse involving Resident #77, and informed the Administrator the next day, on 4/25/2024. The Director of Nursing stated they should have called the New York State Department of Health within the 2 hours of becoming aware of the alleged violation.</p> <p>2) Resident #32 had diagnoses of dementia and generalized osteoarthritis.</p> <p>The Minimum Data Set 3.0, a resident assessment instrument, dated 11/10/2023 documented Resident #32 had severely impaired cognition.</p> <p>The facility Accident/Incident Report dated 12/4/2023 documented staff responded to Resident #32 calling for help and observed the resident sitting on the floor complaining of left wrist pain. The Medical Doctor was made aware, Resident #32 was hospitalized, and x-ray revealed Resident #32 had a closed fracture of their left wrist.</p> <p>There was no documented evidence Resident #32's unwitnessed incident and left wrist fracture were reported to the New York State Department of Health.</p> <p>On 5/08/2024 at 10:18 AM, Registered Nurse #8 was interviewed and stated the Registered Nurses were responsible for initiating investigations of incidents and submitting their completed reports to the Administrator and the Director of Nursing.</p> <p>On 5/08/2024 at 11:02 AM, the Director of Nursing was interviewed and stated they were aware of Resident #32's left wrist fracture. The facility's Accident/Incident Report was completed in a timely manner, but the alleged violation was not reported to the New York State Department of Health.</p> <p>On 5/09/2024 at 10:14 AM, the Administrator was interviewed and stated they were not aware that Resident #32's left wrist fracture was not reported to the New York State Department of Health. The Administrator stated the Director of Nursing had access to the reporting system and should have reported the incident within 2 hours of occurrence.</p> <p>3) Resident #111 had diagnoses of seizure disorder and schizophrenia (a mental condition involving the breakdown in the relation between thought, emotion, and behavior).</p> <p>The Minimum Data Set 3.0, a resident assessment instrument, dated 02/03/2024 documented Resident #111 had moderately impaired cognition.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>- Lesson plans on Abuse, neglect and mistreatment, Behavioral Health, Alzheimer's Disease and Dementia and Incident reporting, with attendance and sign-in sheets were reviewed and documented that 76% (182 of 239) of all staff in serviced, including Certified Nursing Assistants= 80%, Licensed Practical Nurses= 75%, Registered Nurses= 65%, Recreation = 81%, and Social Services= 100%. -Multiple observations were conducted on Resident #77 from 4/24/2024 - 5/09/2024 and no concerns noted.</p> <p>-Team observation on staff while performing resident care did not reveal any sign of abuse, neglect, or mistreatment.</p> <p>Based on observation, interview and record review conducted on 5/03/2024, the facility fully implemented the Immediate Jeopardy Removal Plan, and the Immediate Jeopardy was removed as of 5/03/2024 at 2:00 PM.</p> <p>10 NYCRR 415.4(b)(2)</p> <p>44472</p> <p>18881</p> <p>45351</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/09/2024
NAME OF PROVIDER OR SUPPLIER  Sapphire Center for Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  35 15 Parsons Blvd Flushing, NY 11354	
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)		
<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44864</b></p> <p>Based on record review and interviews conducted during the Recertification and Abbreviated (NY00340290) Survey from 4/29/2024 to 5/9/2024, the facility failed to ensure that all alleged violations involving abuse, neglect, and mistreatment were thoroughly investigated, prevent further potential abuse while an investigation was in progress, and report the results of the investigation to the New York State Department of Health within 5 working days. This was evident for 2 (Resident #77 and Resident #111) of 39 total sampled residents. Specifically, 1) an allegation of staff-to-resident abuse involving Certified Nursing Assistant #1 and Resident #77 occurred on 4/23/2024 and the investigation results were not reported to the New York State Department of Health until 5/3/2024. Additionally, Certified Nurse Assistant #1 was not removed from direct care of residents on the unit until 4/25/2024. 2) Investigations were not conducted when Resident #111 fell on [DATE] and sustained discoloration of unknown origin to their left knuckles on 4/14/2024.</p> <p>This resulted in Substandard Quality of Care that was Immediate Jeopardy which resulted in serious injury for Resident #77 with the likelihood of a serious adverse outcome of occurring to other residents on the unit.</p> <p>The findings are:</p> <p>The facility policy titled Abuse Identification and assessment dated ,d+[DATE] states the facility was required to report the final investigation report to the New York State Department of Health within 5 days of the incident.</p> <p>1) Resident #77 had diagnoses of dementia and osteoarthritis (degeneration of joint cartilage and underlying bone.)</p> <p>The Minimum Data Set 3.0, a resident assessment instrument, dated 1/14/2024 documented Resident #77 was severely cognitively impaired, did not display inappropriate behavior, ambulated with supervision or touch assistance, and required assistance when using a wheelchair.</p> <p>A Comprehensive Care Plan related to potential for abuse and neglect initiated 1/07/2024 and last reviewed 4/24/2024 documented Resident #77 was at risk for abuse due to their dementia diagnosis and one-to-one interaction would be provided until the resident was calm.</p> <p>The facility's video surveillance dated 4/23/2024 at 12:05 PM revealed Resident #77 was in the hallway on their unit and attempted to walk into a room. Certified Nursing Assistant #1 exited the room and stood in between Resident #77 and the entrance to their room. Resident #77 slapped Certified Nursing Assistant #1. Certified Nursing Assistant #1 then struck Resident #77 causing the resident to fall backwards and land on the floor in a supine position (flat on their back). Certified Nursing Assistant #1 grabbed Resident #77's wrists, lifted the resident to their feet, and pulled the resident into their room. Registered Nurse #1 and Certified Nursing Assistant #2 were seated at the nurse's station directly in front of Resident #77 and Certified Nursing Assistant #1 when the incident occurred. Registered Nurse #1 and Certified Nursing Assistant #2 did not intervene during the incident.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility's Accident/Incident Report initiated on 4/23/2024 documented Resident #77 was pacing in the hallway on their unit, hit Certified Nursing Assistant #1, and then fell to the floor causing a left wrist fracture.</p> <p>The Nursing Note written by Registered Nurse #1 was dated 4/23/2024 at 12:08 PM and documented Resident #77 became physically aggressive toward staff, slapped a Certified Nursing Assistant, fell to the floor, and reported left wrist pain. Resident #77's left wrist was swollen, the Medical Doctor was informed, and an x-ray was done. At 10:29 PM, a Registered Nurse on the evening shift documented Resident #77's next of kin requested the resident be sent to the hospital for evaluation and Resident #77 was transferred to the hospital.</p> <p>A Nursing Note dated 4/24/2024 documented Resident #77 returned from the hospital with a cast to their left wrist due to left wrist fracture.</p> <p>The Summary of Investigation completed by the Director of Nursing, dated 4/25/2024, documented video surveillance footage and staff statements were reviewed. Registered Nurse #1 failed to report Resident #77's incident accurately, falsified documentation, and misled the investigation. Abuse of Resident #77 did occur on 4/23/2024.</p> <p>Staffing Attendance Sheets dated 4/23/2024 to 4/25/2024 documented Certified Nursing Assistant #1 worked after the incident on 4/23/2024 at 12:00 PM - their entire shift of 4/23/2024 until 3:00 PM, the entire shift from 7:00 AM to 3:00 PM on 4/24/2024, and from 7:00 AM to 1:00 PM on 4/25/2024 - before being removed from patient care.</p> <p>There was no documented evidence Certified Nursing Assistant #1 was removed from duty to prevent further potential abuse following the incident with Resident #77 on 4/23/2024.</p> <p>There was no documented evidence the facility reported the results of the investigation to the New York State Department of Health into Resident #77's abuse incident until 5/03/2024, more than 5 working days after the investigation initiation.</p> <p>On 5/09/2024 at 2:59 PM, the Director of Nursing was interviewed and stated they were made aware of Resident #77's abuse incident on 4/24/2024. The Director of Nursing did not realize the seriousness of the incident. They stated they should have reported the incident to the New York State Department of Health within 2 hours of occurrence and should have reported the completion of the investigation to the New York State Department of Health within a timely manner. The Director of Nursing further stated they were initially told the incident was a fall occurrence and upon further interview with Registered Nurse #1 on 4/24/2024, they were told that Certified Nursing Assistant #1 hit Resident #77. They completed their investigation on 4/24/2024 and reported the abuse incident to the Administrator on 4/25/2024. They suspended Certified Nursing Assistant #1 on 4/25/2024.</p> <p>18881</p> <p>2) Resident #111 had diagnoses of seizure disorder and schizophrenia (a mental condition involving the breakdown in the relation between thought, emotion, and behavior).</p> <p>The Minimum Data Set 3.0, a resident assessment instrument, dated 2/03/2024 documented Resident #111 had moderately impaired cognition.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Nursing Note dated 4/05/2024 documented Resident #111 was evaluated by the Nurse Practitioner following a fall without injury.</p> <p>The Nursing Note dated 4/14/2024 documented Resident #111 was observed with discoloration to their left knuckles of unknown origin. Resident #111 was unable to state how the discoloration occurred and an ice pack was applied to Resident #111's knuckles.</p> <p>There was no documented evidence Resident #111's fall on 4/05/2024 or the injury of unknown origin to their left knuckles on 4/14/2024, were thoroughly investigated or communicated to the Medical Doctor.</p> <p>On 5/02/2024 at 10:02 AM, Registered Nurse #5 was interviewed and stated they have been covering as the supervisor for the building at times and were responsible for completing the Accident/Incident Reports for the Director of Nursing. Registered Nurse #5 stated there was no Accident/Incident Report or Investigation completed for Resident #111's fall on 4/5/2024 or for the injury to their left knuckles on 4/14/2024.</p> <p>On 5/08/2024 at 12:16 PM, Registered Nurse #15 was interviewed and stated they were made aware of Resident #111's left knuckles discoloration and did not initiate an investigation or report the incident to the Director of Nursing or the New York State Department of Health. Registered Nurse #15 stated they only worked at the facility per diem on the day shift as a supervisor and there was no one available for them to consult with when they did not know how to address an incident or situation.</p> <p>On 4/29/2024 at 8:22 PM, Immediate Jeopardy was identified and declared. The facility's Administrator and the Director of Nursing were notified.</p> <p>On 5/03/2024 at 2:00 PM, a removal plan was implemented, and Immediate Jeopardy was lifted based on the following corrective actions taken by the facility:</p> <ul style="list-style-type: none"> <li>-Termination Letter documents Certified Nursing Assistant #1 was terminated dated 4/26/2024 and letter was sent to Certified Nursing Assistant #1 dated 5/01/2024.</li> <li>-Termination letter documents dated 4/29/2024 for Registered Nurse #1 for failing to accurately report and document instance of abuse, not intervening on behalf of the resident and improperly completing the Accident and Incident Report related to abuse, mistreatment, and Neglect.</li> <li>-Resident #77's care plan was updated on 4/24/2024, and resident was seen by a psychiatrist on 5/02/2024, who documented resident does not appear to be suffering from emotional stress from the incident and will be followed up as necessary.</li> <li>- The facility's investigation regarding abuse allegation was completed on 4/25/2024 by the Director of Nursing.</li> <li>-The policy on Behavior and Dementia Care and Abuse prevention were reviewed 1/2022, 1/2023, 4/2024.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The following documents were received and reviewed. Social worker care plan for abuse prevention was updated, Medical Doctor assessment and evaluation dated 4/24/2024; Registered Nurse assessment dated [DATE].</p> <p>- Lesson plans on Abuse, neglect and mistreatment, Behavioral Health, Alzheimer's Disease and Dementia and Incident reporting, with attendance and sign-in sheets were reviewed and documented that 76% (182 of 239) of all staff in serviced, including Certified Nursing Assistants= 80%, Licensed Practical Nurses= 75%, Registered Nurses= 65%, Recreation = 81%, and Social Services= 100%. -Multiple observations were conducted on Resident #77 from 4/24/2024 - 5/09/2024 and no concerns noted.</p> <p>-Team observation on staff while performing resident care did not reveal any sign of abuse, neglect, or mistreatment.</p> <p>Based on observation, interview and record review conducted on 5/03/2024, the facility fully implemented the Immediate Jeopardy Removal Plan, and the Immediate Jeopardy was removed as of 5/03/2024 at 2:00 PM.</p> <p>10 NYCRR 415.4(b)(3)</p>		