STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335201	A. Building B. Wing	02/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beth Abraham Center for Rehabilitation and Nursing	612 Allerton 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43350 Based on observation, interview, and record review conducted during the recertification survey from 1/29/2024 to 2/5/2024, facility did not ensure that all alleged violations involving abuse were reported immediately, but not later than two hours after occurrence, to the New York State Department of Health, 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. This was evident for 1 (Resident #227) of 38 total sampled residents. Specifically, the facility did not report to the New York State Department of Health when Resident #227 had an unwitnessed incident resulting in a head laceration and left arm fracture. The findings are: Resident #227 had diagnoses of osteoporosis and dementia. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #227 had severe cognitive impairment. The facility Incident Report dated 10/24/2023 documented Resident #227 was heard screaming for help at 4:20 AM and was found on the floor of their room in pain with a forehead laceration and left arm twisted behind them. The Incident Report concluded Resident #227 fell while trying to get out of bed. Nursing Note dated 10/28/2023 documented Resident #227 was readmitted from the hospital with multiple fractures of the left upper extremity. There was no documented evidence Resident #227 unwitnessed incident resulting in head laceration and left arm fracture were reported to the New York State Department of Health. On 02/05/2024 at 11:11 AM, the Director of Nursing was interviewed and stated the facility was required to report to the New York State Department of Health within 2 hours of an occurrence causing major injury to a resident. The facility did not have to report Resident #227's head laceration and left arm fracture because the facility determined the resident sustained the injuries from a fall. (continued on next page)

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	On 02/04/2024 at 2:17 PM, the Corporate Nursing Compliance Officer was interviewed and stated the facility was not required to report Resident #227's injuries to the New York State Department of Health because the facility concluded they were sustained during a fall and no abuse occurred. Even though the incident was unwitnessed, the facility identified Resident #227 as a frequent faller and made the conclusion that injuries sustained were from a fall. 10NYCRR 415.4(b)(2)