

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335227	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2023
NAME OF PROVIDER OR SUPPLIER Workmens Circle Multicare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3155 Grace 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</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>39908</p> <p>Based on observation, record review, and interview conducted during an Abbreviated Survey (NY00325595), the facility failed to protect a resident's right to be free from physical abuse by nursing home staff. This was evident in 1 out of 5 residents (Resident #1) reviewed for abuse. Specifically, on 10/07/23 at approximately 6:06pm, the facility's surveillance camera recording showed Resident #1 struck Certified Nursing Assistant (CNA) #1 with a headphone. CNA #1 then hit Resident #1 on the back of their head. Additionally, CNA #2, #3, and CNA #4 witnessed CNA #1 hit Resident #1 at the back of their head. Registered Nurse Supervisor (RNS) #1 assessed Resident #1 who had no visible injuries.</p> <p>The findings are:</p> <p>The facility policy on Reporting and Investigation of Resident Abuse, Neglect, Misappropriation/Exploitation, and Mistreatment dated 10/2022 states that the facility will not use or permit physical abuse. This prohibition extends to abuse by anyone, including but not limited to, other residents, staff, consultants, volunteers, and staff of other agencies serving the residents, or other individuals.</p> <p>Resident #1 was admitted to the facility with diagnoses of End Stage Renal Disease and Type 2 Diabetes Mellitus.</p> <p>The Minimum Data Set (MDS, a resident assessment tool) dated 07/20/2023 documented that Resident #1 had intact cognition.</p> <p>An Abuse Care Plan for Resident #1 was implemented on 05/17/2023. The interventions documented that staff should advise Resident #1 to seek out staff assistance if having difficulty with others, to calmly redirect resident away from potential harm, and to intervene as necessary to ensure safety.</p> <p>A Health Status Note by RNS #1, dated 10/07/2023 at 9:38pm documented that on 10/07/2023 at approximately 6:15pm, Resident #1 wheeled themselves to Unit #2 dining hall to ask for a sandwich. CNA #1 told Resident #1 that sandwiches on the unit are for other residents. CNA #1 tried to redirect Resident #1 towards their unit. Resident #1 started to argue with CNA #1 and hit CNA #1 with their earphones. CNA #1 hit Resident #1 on the left side of their head.</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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's summary of investigation dated 10/07/2023 documented in their conclusion that staff statements and review of the camera footage showed CNA #1 hit Resident #1 at the back of Resident #1's neck instead of calling for assistance or walking away. Resident #1 was assessed with no visible injuries. A skull x-ray revealed no abnormality. The Occurrence Investigative Form documented that there was probable evidence of abuse since CNA #1 hit Resident #1.</p> <p>The facility's surveillance camera recording reviewed with the Director of Nursing (DON) on 10/17/2023 at 12:09pm. Camera #1 showed on 10/07/2023 at 6:06pm, Resident #1 wheeled themselves into the dining room towards CNA #1. Resident #1 and CNA #1 were both motioning and gesturing with their hands. Resident #1 approached the table where CNA #1 was standing and tried to reach for an item on the table. CNA #1 tried to stop Resident #1 from touching the items on the table. CNA #1 approached Resident #1 from behind their wheelchair and wheeled Resident #1 away from the dining room. Camera #3 showed Resident #1 hit CNA #1's left hand with their right hand while being wheeled. CNA #1 continued wheeling Resident #1 in the hallway. Resident #1 dropped their headphones on the floor and CNA #1 picked up the headphone and gave it back to Resident #1. CNA #1 continued to push Resident #1's wheelchair and stopped in the hallway. Resident #1 was observed hitting CNA #1 with their headphone. CNA #2 stepped out of a resident's room and tried to stop Resident #1 from hitting CNA #1. CNA #3 stepped out of the same room and as CNA #3 was moving to the back of Resident #1's wheelchair, CNA #1 struck Resident #1 in the back of Resident #1's head with their right hand. CNA #2 and CNA #3 pushed CNA #1 away from Resident #1 and CNA #1 walked away from camera view.</p> <p>During an interview on 10/17/2023 at 10:55am, Resident #1 stated they wheeled themselves to the dining room last Saturday (10/07/23) to asked for a sandwich. Resident #1 stated that they went over to the table where CNA #1 was standing and started checking the food items on the table. Resident #1 stated that CNA #1 got upset, tapped Resident #1's hand, and wheeled Resident #1 back to their room. Resident #1 stated that they hit CNA #1 with their headphone and CNA #1 hit Resident #1 on the left side of Resident #1's neck with CNA #1's right fist. Resident #1 stated that they were not hurt and that they did not feel any pain. Resident #1 stated that the Police Officers came to their room to speak about the incident.</p> <p>During an interview on 10/17/2023 at 1:30pm, CNA #1 stated that on 10/07/2023 at approximately 6:00pm, Resident #1 began cursing at CNA #1 because CNA #1 did not have a sandwich. CNA #1 stated that they wheeled Resident #1 out of the dining room and Resident #1 swung their headphone and hit CNA #1 on the face. CNA #1 stated that they tried to push Resident #1's hand away and accidentally touched Resident #1's head. CNA #1 stated that they did not hit Resident #1.</p> <p>During an interview on 10/17/2023 and 10/18/2023, CNA #2 stated that they witnessed CNA #1 strike Resident #1 on the back of Resident #1's head. CNA #2 stated that they heard a slapping sound but Resident #1 did not have a reaction to the slap.</p> <p>During an interview on 10/17/2023 and 10/18/2023, CNA #3 and CNA #4 stated that they witnessed CNA #1 strike Resident #1 in the back of Resident #1's neck. Both CNA #2 and CNA #4 stated that CNA #1 hit Resident #1 with an open hand. CNA #4 stated that CNA #3 separated CNA #1 and Resident #1, and that CNA #4 called Registered Nurse (RN) #1 immediately.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/19/2023 at 3:13pm, the Director of Nursing (DON) stated that on the evening of 10/07/2023, they received a call from RNS #1 stating that CNA #1 hit Resident #1. The DON stated they went to the facility and initiated an investigation. The DON stated that they reviewed the surveillance camera recording and observed that CNA #1 hit Resident #1. The DON also stated that the incident was witnessed by other staff on the unit. The DON stated that the investigation concluded that abuse did occur.</p> <p>During an interview on 10/19/2023 at 3:45pm, the Administrator stated that the DON notified them of the incident right away. The Administrator stated that based on their investigation, abuse had occurred.</p> <p>10 NYCRR 415.4(b)(1)(ii)</p>		