

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335248	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/02/2024
NAME OF PROVIDER OR SUPPLIER  Fieldston Lodge Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  666 Kappock Street Riverdale, NY 10463	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39136</p> <p>Based on record review and interviews conducted during the Recertification and Abbreviated Survey (Complaint #NY00331841) from 03/26/2024 through 04/02/2020, the facility failed to ensure that the resident and/or the resident's representative was immediately informed of an accident which results in injury and had the potential for requiring physician intervention. This was evident for 1 (Resident #253) of 2 residents reviewed for Notification of Change out of 38 total sampled residents. Specifically, on 01/15/2024 at 6:30 AM, Resident #253 was observed with discoloration on the forehead. There was no documented evidence that the resident's representative was notified of the change in resident's condition.</p> <p>The findings are:</p> <p>The facility policy and procedure titled Change in Resident Condition or Status which was last revised in November 2023, documented that the facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and status (e. g., changes in level of care, billing/payments, resident rights, etc.). Unless otherwise, instructed by the resident, a nurse will notify the resident's representative when the resident is involved in any accident or incident that results in an injury including injuries of an unknown source.</p> <p>Resident #253 was admitted with diagnoses of Hypertension and Non-Alzheimer's Dementia.</p> <p>The annual Minimum Data Set assessment dated [DATE] documented that Resident #253 had short- and long-term memory problem and was severely impaired in cognitive skills for daily decision making.</p> <p>A Nurse's Progress note dated 01/15/2024 at 6:40 AM documented that at 6:30 AM, Resident #253 was noted with skin discoloration on the forehead.</p> <p>A Nurse's Progress note dated 01/16/2024 at 5:28 AM documented that skin discoloration on Resident #253's forehead was diffusing.</p> <p>The progress notes dated 01/15/2024 through 01/16/2024 had no documented evidence that the family was informed of the discoloration on Resident #253's forehead.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Fall Investigation form dated 01/15/2024 and Peer Review and the Quality Assessment and Assurance Work Product-Confidential form dated 01/15/2024 had no documented evidence that Resident #253's family was informed of the discoloration.</p> <p>The facility's investigation summary dated 01/17/2024 documented that Resident #253 was observed with a discoloration to the center of their forehead on 01/15/2024 during care. The facility concluded that Resident #253 sustained an unwitnessed fall in their room which appeared to have occurred from rolling out of bed in their sleep.</p> <p>On 03/27/2024 at 3:13 PM, Resident #253's representative was interviewed and stated that their sibling visited the resident on 01/16/2024 and observed that the resident had black and blue on their forehead. The facility claimed that they informed them, but they were not informed.</p> <p>On 04/01/2024 at 11:51 AM, Registered Nurse #1, who was the unit manager, was interviewed and stated that the night shift supervisor wrote a note that at 6:30 AM, discoloration was noted on Resident #253's forehead. Registered Nurse #1 stated they did not see a documentation on the resident's chart that the family were notified.</p> <p>On 04/02/2024 at 8:40 AM, Registered Nurse #2, who was the night shift supervisor, was interviewed and stated that on 01/15/2024 at around 6:30 AM, they were called to check on Resident #253 who was noted to have discoloration on the forehead. Registered Nurse #2 stated they called the physician and left a message for the family. Resident #2 stated they might have misdialled the phone number, or they might have had an emergency at that time and might have not called or notified the resident's family.</p> <p>On 04/02/2024 at 2:03 PM, the Director of Nursing was interviewed and stated that the unit manager and supervisors were responsible for notifying the family. They stated that the night shift supervisor stated they reached out to the family and left a voice message but there was no documentation that the family was notified. The Director of Nursing stated they were supposed to document when they called the family.</p> <p>10 NYCRR 415.3(f)(2)(ii)(c)</p>		

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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>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> 39136</p> <p>Based on record review and interviews conducted during the Recertification and Abbreviated Survey (NY00331841) from 03/26/2024 through 04/02/2024, the facility failed to ensure that all alleged violations involving injuries of unknown source were reported immediately, but not later than 2 hours after the allegation was made, to the New York State Department of Health. This was evident for 1 (Resident #253) of 38 total sampled residents. Specifically, on 01/15/2024 at 6:30 AM, Resident #253 was observed with discoloration to the forehead that was not reported to the New York State Department of Health. There was no witness on how Resident #253 sustained the discoloration and the source of injury could not be explained by the resident.</p> <p>The findings are:</p> <p>The facility policy and procedure titled Abuse &amp; Neglect, with a last revised date of 03/18/2024 documented that all alleged or suspected incidents of abuse and or neglect will be investigated, and injuries of unknown origin will be investigated to rule out abuse, neglect, or mistreatment. The Administrator or designee will provide a 2-hour notification to the New York State Department of Health for any alleged or suspected or confirmed case of abuse or neglect.</p> <p>Resident #253 was admitted with diagnoses of Hypertension and Non-Alzheimer's Dementia.</p> <p>The annual Minimum Data Set assessment dated [DATE] documented that Resident #253 had short- and long-term memory problem and was severely impaired in cognitive skills for daily decision making.</p> <p>A Nurse's Progress note dated 01/15/2024 at 6:40 AM documented that at 6:30 AM Resident #253 was noted with skin discoloration on the forehead.</p> <p>A Fall Investigation form dated 01/15/2024 documented that the occurrence was unwitnessed.</p> <p>An undated Skin Investigation form documented Resident #253 was observed in bed with discoloration to the forehead. Resident was unable to relate due to dementia.</p> <p>The facility's investigation summary dated 01/17/2024 documented that Resident #253 was observed with a discoloration to the center of their forehead on 01/15/2024 during care. The facility concluded that based on their findings, there was no evidence of abuse, neglect, or mistreatment. The summary documented that Resident #253 sustained an unwitnessed fall in their room which appeared to have occurred from rolling out of bed in their sleep.</p> <p>On 04/02/2024 at 2:03 PM, the Director of Nursing stated that Resident #253 was interviewed but could not tell what happened. The Director of Nursing stated they did not report the discoloration to the Department of Health because they thought it was from a fall based on the roommate's statement. They stated that the resident's roommate said they did not see the resident fall, but they saw the resident getting up from the floor. The Director of Nursing stated they completed the incident report and concluded that it appeared that Resident #253 rolled out of bed.</p> <p>(continued on next page)</p>		

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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>10 NYCRR 415.4(b)(2)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>45351</p> <p>Based on record review and interviews conducted during the Recertification and Complaint Survey (NY00327454) from 03/26/2024 through 04/02/2024, the facility did not ensure that each resident's comprehensive care plan was reviewed and revised by the interdisciplinary team following an occurrence of resident-to-resident physical abuse. This was evident for 1 (Resident #35) of 35 total sampled residents. Specifically, the comprehensive care plan was not reviewed and revised for Resident #35 following their involvement in a resident-to-resident altercation.</p> <p>The findings are:</p> <p>The facility policy titled Comprehensive Care Plan dated 10/2023 documented a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.</p> <p>Resident #35 was admitted to the facility with diagnoses of Diabetes Mellitus, Acute Respiratory Failure, and Bipolar Disorder.</p> <p>The Minimum Data Set assessment dated documented that Resident #35 had severely impaired cognition.</p> <p>The facility investigation summary documented that on 11/04/2023 at 6:35AM, Resident #35 was involved in an unwitnessed altercation with another resident in their room. Both residents were transferred to the hospital for evaluation. Resident #35 returned to the facility with staples to the head.</p> <p>A comprehensive care plan for psychosocial well-being that was initiated on 12/13/2022 documented resident evidences the potential for abuse due to cognitive and medical decline.</p> <p>There was no documented evidence that Resident #35's comprehensive care plan was revised with new interventions following an occurrence of resident-to-resident altercation on 11/04/2023.</p> <p>On 04/01/2024 at 9:06AM, Registered Nurse #7, who was the Registered Nurse Supervisor, stated Resident #35 was involved in an altercation with another resident on 11/04/2023. Registered Nurse #7 stated they reviewed Resident #35's medical record and was not able to find an updated care plan with new interventions for Resident #35 following the altercation. Registered Nurse #7 stated that care plans must be updated after each incident of altercation.</p> <p>10 NYCRR 415.11(c)(2)(i-iii)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45351</p> <p>Based on observation, record review and interviews conducted during the Recertification and Complaint Survey (NY00318593) from 03/26/2024 through 04/02/2024, the facility did not ensure that each resident receives treatment and care in accordance with professional standards of practice. This was evident for 1 (Resident #99) of 35 total sampled residents. Specifically, on 03/29/2024, Resident #99's right and left lower extremities were observed with severe edema, dry, and thick scaly skin. There was no documented evidence that the skin condition was evaluated and being treated.</p> <p>The findings are:</p> <p>The facility's policy and procedure titled Quality of Care dated 11/2023 documented each resident shall be cared for in a manner that promotes and enhances their quality of life, dignity, respect, and individuality.</p> <p>Resident #99 was admitted to the facility with diagnoses of Acute Embolism and Thrombosis of Unspecified Deep Veins of Right Lower Extremity, Cellulitis of Right/Left Lower Limbs, and Localized Edema.</p> <p>The Minimum Data Set assessment dated [DATE] documented Resident #99 was cognitively intact.</p> <p>During observation on 03/29/2024 at 1:00 PM, Resident #99's right and left lower extremities were noted with redness, severe edema, dry, and thick scaly skin.</p> <p>A care plan for at risk for skin impairment related to fragile skin was initiated on 11/05/2021 and was last reviewed on 02/18/2024. The facility interventions include to conduct a systematic skin inspection daily and weekly, to pay particular attention to unaffected extremity. An evaluation note dated 01/24/2024 documented there was no skin impairment noted.</p> <p>The podiatry note dated 01/27/2024 and 02/25/2024 documented Resident #99 presented for routine foot care. Resident had severe pitting edema of bilateral lower extremities with open lesions.</p> <p>A review of Resident #99's progress notes from 01/03/2024 through 03/29/2024 did not reveal documented evidence that Resident #99's bilateral lower extremities were assessed by the Registered Nurse, Nurse Practitioner, or the Attending Physician.</p> <p>A review of the physician's order report from 01/01/2024 through 03/29/2024 did not show treatment orders to address Resident #99's dry and thick scaly skin on both lower extremities.</p> <p>On 03/29/2024 at 1:00 PM, Resident #99 was interviewed and stated nurses were aware of their skin condition but does not provide them with treatment.</p> <p>On 04/01/2024 at 9:17 AM, Licensed Practical Nurse #4 was interviewed and stated there was no current order for Resident #99's skin on bilateral lower extremities.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/02/2024 at 11:15 AM, the Assistant Director of Nursing was interviewed and stated Resident #99 had history of cellulitis and ongoing localized edema of bilateral lower extremities. They stated Resident #99's treatment orders were discontinued last year.</p> <p>On 04/02/2024 at 12:30 PM, the Attending Physician was interviewed and stated Resident #99's had lower extremity edema and chronic skin condition. The attending physician stated there was no report of change or concern for Resident #99, and if there was any reported concern, they would evaluate the resident and order appropriate treatment.</p> <p>10 NYCRR 415.12</p>		