| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335248 | A. Building<br>B. Wing | 04/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Fieldston Lodge Care Center | 666 Kappock Street<br>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) |
|---|---|
| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48907<br><br>Based on observation, record review, and interviews conducted during an abbreviated survey (NY00320218), the facility did not ensure that a resident was free from physical abuse by nursing home staff. This was evident for 1 out of 3 residents sampled for abuse (Resident #1). Specifically, on 07/17/23 at 11:37:25 am, Resident #1, who was cognitively intact, reported to the Assistant Director of Nursing they were punched in the nose by Licensed Practical Nurse #1. Review of the facility's surveillance camera dated 07/17/23 at 11:37 am (real time) showed Licensed Practical Nurse #1 exiting Resident #1's room, retrieved their belongings, and exited the nursing unit. Resident #1 was seen crawling on hands and knees on the floor bleeding. Licensed Practical Nurse #1 left the nursing unit without reporting to Registered Nurse Supervisor #1 that Resident #1 was injured, or how Resident #1's injuries occurred. This resulted in actual harm to Resident #1 that was not Immediate Jeopardy.<br><br>The findings are:<br><br>The Facility's Policy and Procedure on Abuse and Neglect, revised date of 01/23, documented the facility assures that residents are free from abuse and neglect by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, family members, legal guardians, or outside members of the community. All Employees will be trained and be knowledgeable about the Abuse Prevention Policy. The Abuse Prevention policy will be incorporated into the employee orientation procedure. A mandatory annual in-service for all facility staff will be provided.<br><br>Resident #1 was admitted on [DATE] to the facility with diagnoses including Depression and Alcohol abuse with intoxication.<br><br>The Minimum Data Set, dated dated [DATE], documented that Resident #1 had a Brief Interview of Mental Status and scored 14 out of 15, indicating intact cognition.<br><br>A Comprehensive Care Plan for Psychosocial well-being, dated 09/27/22, documented Resident #1 potential for abuse due to cognitive and medical decline, documented interventions to allow Resident #1 to verbalize any questions or concerns.<br><br>A Comprehensive Care Plan for Behavioral symptoms, dated 01/27/24, documented interventions to provide physical and verbal cues to alleviate anxiety, assist verbalization of source of agitation, and encourage seeking out for staff member when agitated.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A nursing progress note written by Assistant Director of Nursing, dated 07/17/23 at 5:47 pm, documented they were called by Social Worker #1 to the unit at 10:00 am, because Resident #1 had headbutted Licensed Practical Nurse #1. Assistant Director of Nursing and Social Worker #1 calmed Resident #1, and Resident #1 apologized to Licensed Practical Nurse #1. At around 11:30 am, Assistant Director of Nursing #1 was called onto the unit because Resident #1 was bleeding on the floor. Assistant Director of Nursing #1 responded and observed Resident #1 lying in a prone position in the hallway, bleeding from their nose. Resident #1 stated to Assistant Director of Nursing #1 that Licensed Practical Nurse #1 punched Resident #1 twice in their face. Resident #1 was assessed, and stated they were fine. The Medical Doctor was notified and ordered to transfer Resident #1 to the hospital for a computerized tomography scan. Resident #1's family member was notified about the incident and the transfer of Resident #1 to the hospital.<br><br>The facility's Occurrence report, dated 07/17/23 at 11:36 am, documented Resident #1 stated Licensed Practical Nurse #1 punched them. Resident #1 was observed bleeding from their nose on the floor in the hallway close to their room. Resident #1 was assessed, Medical Doctor informed, and 911 was called at 11:55 am. Resident #1 was transferred to the hospital for further evaluation.<br><br>The facility concluded that abuse occurred because License Practical Nurse #1 was inconsistent with their statement during a telephone interview, and the surveillance footage showed Licensed Practical Nurse #1 exiting the room shortly before Resident #1 was seen crawling and bleeding. Administrator #1, Director of Nursing #1, Assistant Director of Nursing and Social Worker #1 responded to the call that Resident #1 was seen bleeding on the floor and Licensed Practical Nurse #1 could not be located. When Administrator #1 asked Licensed Practical Nurse #1 if they punched Resident #1, Licensed Practical Nurse #1 informed the Administrator they would not let a resident abuse them.<br><br>Hospital Discharge Summary (imaging report), dated 07/17/23 at 3:34 pm, documented that an x-ray of Resident #1's right elbow, revealed the elbow was fractured, and a computerized tomography scan (CAT Scan) of Resident #1's face revealed a nasal bone fracture (nose fracture).<br><br>During an interview on 03/18/24 at 1:08 pm, Resident #1 stated Licensed Practical Nurse #1 told them to go to their room. Resident #1 stated Licensed Practical Nurse #1 came into the room, and they had something metal in their hand and Licensed Practical Nurse #1 punched them several times. Resident #1 stated they were unaware of any witnesses. Resident #1 cannot remember the date or time.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a telephone interview on 03/18/24 at 2:36 pm, Licensed Practical Nurse #1 stated Resident #2 was causing a disturbance on the unit and was disturbing Resident #1. Licensed Practical Nurse #1 stated they were trying to de-escalate the issue between the residents when Resident #1 became aggressive, and headbutted Licensed Practical Nurse #1 in front of Social Worker #1, Registered Nurse Supervisor #1, and Director of Nursing. Licensed Practical Nurse #1 stated they called Director of Nursing later that day to ask if police would be called because Resident #1 headbutted them. Director of Nursing said they would follow up with Licensed Practical Nurse #1 later. Licensed Practical Nurse #1 stated they went into the room to provide care at the end of the shift to Resident #3 when Resident #1 approached Licensed Practical Nurse #1 to apologize. Licensed Practical Nurse #1 stated Resident #1 became angry because Licensed Practical Nurse #1 did not want to accept Resident #1's apology, so Resident #1 grabbed a pouch/grooming kit, pulled out scissors, and charged at Licensed Practical Nurse #1. Licensed Practical Nurse #1 stated Resident #1 was blocking the door when Licensed Practical Nurse #1 was attempting to exit, so Licensed Practical Nurse #1 pushed Resident #1 out their way and Resident #1 dropped themselves on the floor to create a scene. Licensed Practical Nurse #1 stated they left the facility at approximately 1:20 pm and called the facility 10 minutes later to notify the Administrator and the Director of Nursing that Resident #1 had a weapon (scissors), and that Licensed Practical Nurse #1 was going to urgent care. During that conversation, Licensed Practical Nurse #1 stated Administrator #1 informed Licensed Practical Nurse #1 that Resident #1 was injured. Licensed Practical Nurse #1 stated they believe Resident #1 could have injured themselves when Resident #1 put themselves on the floor. Licensed Practical Nurse #1 stated they did not punch or hit Resident #1.<br><br>During an interview on 03/18/24 at 1:05 pm, Assistant Director of Nursing #1 stated they were called to the unit to assess Resident #1, and when they arrived on the unit, they observed Resident #1 in a prone position bleeding from their nose. Assistant Director of Nursing #1 stated Resident #1 reported to them that Licensed Practical Nurse #1 hit them.<br><br>During a telephone interview on 03/19/24 at 10:04 am, Social Worker #1 stated they arrived on the unit at approximately 10:40 am and saw Resident #1 and Licensed Practical Nurse #1 exchanging words back and forth. Social Worker #1 intervened and calmed Resident #1 down. Social Worker #1 stated after Resident #1 was calm, Resident #1 headbutted Licensed Practical Nurse #1. Social Worker #1 stated at approximately 11:36 am, they and Assistant Director of Nursing #1 responded to a call on the unit about Resident #1 bleeding and Resident #1 reported that they were punched in their nose by Licensed Practical Nurse #1.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a telephone interview on 03/19/24 at 1:39 pm, Director of Nursing #1 stated on 07/17/23, they received a call from the nursing unit because Resident #1 was agitated. Director of Nursing #1 stated when they arrived on the unit, Social Worker #1, Licensed Practical Nurse #1, and Resident #1 were present. Licensed Practical Nurse #1 and Resident #1 informed Director of Nursing #1 that Resident #1 headbutted Licensed Practical Nurse #1. (Director of Nursing #1 stated that they could not recall the time.) Director of Nursing #1 stated they asked Licensed Practical Nurse #1 if they were okay, and if they wanted to go to the hospital. Licensed Practical Nurse #1 stated they were fine. Director of Nursing #1 stated Social Worker #1 and Assistant Director of Nursing #1 were in the process of checking for an empty room on a different unit to transfer Resident #1, when they received a second call at approximately 11:36 am from the unit, informing them that Resident #1 was bleeding on the floor. Director of Nursing #1 stated they, Administrator #1, and the Director of Human Resources responded to the call. Licensed Practical Nurse #1 could not be located. Director of Nursing #1 stated that after several attempts to reach Licensed Practical Nurse #1 to inquire about what happened, Licensed Practical Nurse #1 answered their phone and stated that they could not talk.<br><br>During a telephone interview on 03/19/24 at 2:15 pm, Certified Nursing Assistant #1 stated at approximately 11:20 am, they heard someone crying out for help down the hallway, walked towards the cry, and saw Licensed Practical Nurse #1 exiting Resident #1's room. Certified Nursing Assistant #1 stated that a few seconds later they saw Resident #1 crawling on the floor from their room bleeding and Resident #1 told them that Licensed Practical Nurse #1 hit them.<br><br>During a telephone interview on 03/19/24 at 9:41 am, Housekeeper #1 stated around 11:00 am, they heard screaming for help and saw Licensed Practical Nurse #1 coming out of Resident #1's room and Resident #1 was seen crawling on the floor from their room bleeding. Housekeeper #1 stated that Resident #1 stated to them that Licensed Practical Nurse #1 beat them.<br><br>During an interview on 03/18/24 at 1:50 pm, Administrator stated Social Worker #1 observed when Resident #1 headbutted Licensed Practical Nurse #1. Administrator #1 stated they watched the surveillance camera and saw Licensed Practical Nurse #1 went into Resident #1's room at 11:35 am. Administrator #1 stated Licensed Practical Nurse #1 was not carrying any medication in their hand or the medication cart, or any other items that would indicate they entered the room to provide care to Resident #2. Licensed Practical Nurse #1 exited Resident #1's room at 11:37 am and immediately retrieved their belongings and left the facility. Administrator #1 stated that 911 was called at 11:55 am and Resident #1 was transferred to the emergency room .<br><br>10 NYCRR 415.4(b)(1)(i) |