

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 08/01/2024
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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49169</p> <p>Based on observation, interviews, and record reviews conducted during Abbreviated Survey (NY00348529), the facility failed to protect a resident from physical abuse by nursing home staff. This was evident in 1 out of 3 residents (Resident #1) sampled for abuse. Specifically, the facility's surveillance camera recording dated on 07/17/2024 at 4:56pm showed Resident #1 hit Receptionist #1's face and Receptionist #1 retaliated and hit Resident #1 on the top of their head. Resident #1 was assessed by Registered Nurse Supervisors #1 and #2 and there were no visible injuries.</p> <p>The findings are:</p> <p>The facility's Policy and Procedure titled Abuse Prevention and Reporting was last revised on 03/18/2024. The policy states that residents will be free from abuse, neglect, mistreatment, exploitation, or misappropriation of property which include the following components: Screening, Timing, Prevention, Identification, Investigation, Protection and Reporting/response.</p> <p>Resident #1 was admitted to the facility with diagnoses including Depression, Schizophrenia, and Bipolar Disorder.</p> <p>A Minimum Data Set, dated dated [DATE] documented that Resident #1's cognition was intact. There were no mood or behavioral symptoms documented present.</p> <p>A Psychosocial Well-Being Care Plan initiated 02/06/2022 documented that Resident #1 had the potential to be abused due to cognitive and medical decline. The interventions include Social Worker to establish a good rapport, monitor for any alteration in Psychosocial well-being, and refer to medical doctor. The care plan also documented that an evaluation was done on 07/15/2024 and that Resident #1 was transferred to the emergency room for suicidal ideation, aggressive behavior, throwing items at staff, and throwing milk on a staff stating, I will kill one of you before you kill me. Resident #1's loud and aggressive behavior was disturbing on the unit.</p> <p>The care plan was not updated to reflect on the abuse incident of 07/17/2024.</p> <p>A Behavioral Comprehensive Care Plan dated 09/20/2023 documented Resident #1 has socially inappropriate/disruptive behavioral symptoms. The interventions include staff to assess and anticipate the resident needs and to intervene if necessary. Avoid over stimulation. This care plan was last updated on 07/15/2024.</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 care plan was not updated to reflect on the abuse incident of 07/17/2024.</p> <p>The surveillance camera recording dated 07/17/2024 was reviewed on 07/29/2024 at 10:04am with the Administrator and Assistant Administrator. According to the Assistant Administrator, the timestamped on the surveillance record was 2 hours behind real time. The surveillance camera recording showed:</p> <p>At 07/17/2024 at 2:56:20pm (real time 4:56:20pm), Resident #1 was sitting in their wheelchair in the lobby facing the elevator.</p> <p>At 2:56:24pm (4:56:24pm), Receptionist #1 walked over to Resident #1. Receptionist #1's mouth appeared to be moving (talking to Resident #1). Receptionist #1's hand could be seen touching the displays on the wall in between the two elevators. Resident #1 reached out and grabbed the displays on the wall and Receptionist #1 pulled Resident #1's hand off the displays.</p> <p>At 2:56:30pm (4:56:30pm), Receptionist #1 walked away from Resident #1 while making hand gestures (Assistant Administrator stated that Receptionist was calling for help). Receptionist #1 then walked back to the elevator where Resident #1 was still sitting.</p> <p>At 2:56:35pm (4:56:35pm), the Assistant Administrator appeared in the lobby in camera's view and walked over to the elevators where Resident #1 and Receptionist #1 were.</p> <p>At 2:56:40pm (4:56:40), Assistant Administrator held Resident #1's wheelchair from behind, pushing the wheelchair away from elevators and Receptionist #1. Resident #1 reached around the Assistant Administrator and hit Receptionist #1's face. Receptionist #1 walked back (a few steps) to Resident #1 and hit Resident #1 on the top of their head as the Assistant Administrator was pushing the wheelchair away from the elevator. Camera recording ended.</p> <p>The Accident/Incident Report dated 07/17/2024, at 4:45pm documented Resident #1 swung at Receptionist #1 and Receptionist #1 hit Resident #1 on the head. Resident #1 was assessed by Registered Nurse Supervisors #1 and #2 and there was no visible injury. Resident #1 was transferred to the hospital at 5:55pm for psychiatric evaluation. The investigation concluded that abuse did occur.</p> <p>During an interview on 07/29/2024 at 12:25pm, Receptionist #1 stated that Resident #1 came down into the lobby and started ripping the sign off the wall. Receptionist #1 stated that they went over to Resident #1 and told Resident #1 to stop. Receptionist #1 stated that they (Receptionist #1) put their hand on the wall to prevent Resident #1 from removing the sign. Receptionist #1 stated that Resident #1 used their wheelchair to pin Receptionist #1 to the wall. Receptionist #1 stated that they were trying to prevent Resident #1 from hitting them as they tried to unpin themselves. Receptionist #1 stated that they did not hit Resident #1. Receptionist #1 stated that they have been working in the facility for over [AGE] years and would never hit a resident.</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 07/29/2024 at 12:17pm, the Assistant Administrator stated that Receptionist #1 called them to assist with Resident #1 who was trying to remove the sign from the wall. The Assistant Administrator stated that Receptionist #1 was trying to go behind Resident #1's wheelchair to reattach the sign and Resident #1 backed their wheelchair into Receptionist #1. The Assistant Administrator stated that they immediately intervene and while they were in the process of protecting Resident #1, Resident #1 threw a punch at Receptionist #1's face. The Assistant Administrator stated that Receptionist #1 pat over Resident #1's head. The Assistant Administrator stated that they don't know if the pat on the head was hard or soft. The Assistant Administrator stated that they are willing to testify if needed.</p> <p>During an interview on 07/30/2024 at 12:10am, the Director of Nursing stated that they were notified of the abuse incident on 07/17/2024 at approximately at 4:46pm by the Registered Nurse Supervisor #1. The Director of Nursing stated that they were informed that Resident #1 was trying to get the Ombudsman's number from the wall and Receptionist #1 held Resident #1's hand. The Director of Nurse also stated that Resident #1 swung their hand and hit Receptionist #1's face and Receptionist #1 hit Resident #1 on the top of their head. The Director of Nursing stated that Resident #1 was immediately separated from Receptionist #1 by the Assistant Administrator. The Director of Nursing stated that 911 was called and the police responded. The Director of Nursing went on to say that Resident #1 was assessed by Registered Nurse Supervisors with no visible injuries observed. The Director of Nursing stated that Resident #1 was agitated and aggressive and was transferred to the hospital for psychiatric evaluation. The Director of Nursing stated that the police review the video footage and confirmed that Receptionist #1 hit Resident #1 on the head.</p> <p>10 NYCRR 415.4(b)(1)(i)</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49169</p> <p>Based on staff interviews and record review conducted during an abbreviated survey (NY00348529), the facility did not ensure that the comprehensive care plan was reviewed and revised by the interdisciplinary team after a significant change. This was evident for 1 out of 4 residents (Resident #1) sampled. Specifically, the facility's surveillance camera recording dated 07/17/2024 showed Resident #1 was involved in an altercation with Receptionist #1. Resident #1 hit Receptionist #1 and Receptionist #1 retaliated and hit Resident #1 on the top of their head. Resident #1's Psychosocial Well-Being Care Plan was not updated to reflect on the abuse incident of 07/17/2024.</p> <p>The findings include:</p> <p>The facility Policy and Procedure for Comprehensive Care Plan revised on 10/2023 documented the interdisciplinary team in junction with the resident and their family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The comprehensive, person-centered care plan is developed within seven days of the completion of the required Minimum Data Set assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission.</p> <p>Resident #1 was admitted to the facility with diagnoses including Depression, Schizophrenia, and Bipolar Disorder.</p> <p>The Minimum Data Set, dated dated dated [DATE] documented Resident #1's cognition was intact.</p> <p>A Psychosocial Well-Being Care Plan initiated 02/06/2022 documented that Resident #1 had the potential to be abused due to cognitive and medical decline. The interventions include Social Worker to establish a good rapport, monitor for any alteration in Psychosocial well-being, and refer to medical doctor. The care plan also documented that an evaluation was done on 07/15/2024 and that Resident #1 was transferred to the emergency room for suicidal ideation, aggressive behavior, throwing items at staff, and throwing milk on a staff stating, I will kill one of you before you kill me. Resident #1's loud and aggressive behavior was disturbing on the unit.</p> <p>The care plan was not updated to reflect on the abuse incident of 07/17/2024.</p> <p>A Behavioral Comprehensive Care Plan dated 09/20/2023 documented Resident #1 has socially inappropriate/disruptive behavioral symptoms. The interventions include staff to assess and anticipate the resident needs and to intervene if necessary. Avoid over stimulation. This care plan was last updated on 07/15/2024.</p> <p>The care plan was not updated to reflect on the abuse incident of 07/17/2024.</p> <p>During an interview on 07/29/2024 at 1:55pm, the Director of Social Services stated that they are responsible for implementing the Psychosocial Well-being Care Plans. The Director of Social Services went on to say that the Registered Nurses and Supervisors are also responsible for initiating and updating the care plans.</p> <p>(continued on next page)</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>During an interview on 07/30/2024 at 12:10am, the Director of Nursing stated that the Registered Nurse Supervisor who was on duty at the time of the incident on 07/17/2024, was responsible for updating the care plan. The Director of Nursing stated that Registered Nurse Unit Manager #1 should have followed up to ensure the care plan was updated.</p> <p>10 NYCRR 415.11 (c)(2) (i-iii)</p>		