STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335248	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fieldston Lodge Care Center	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)
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. (continued on next page)

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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interviews conducted during an Abbreviated Survey (NY00362877), the facility did not ensure that the alleged violations involving abuse, neglect, exploitation, mistreatment, or misappropriation of resident property were reported immediately, but not later that two (2) hours after the allegation is made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involved abuse and do not involve serious bodily injury, to the administrator of the facility and to other officials (including to the State Agency). This was evident in one (1) out of three (3) residents (Residents #3 and #4) sampled. Specifically, on 12/02/2024 at 7:12 AM, Resident #4 stated that Resident #3 threw a chair, and the chair hit them on their back. The facility reported the incident to New York State Department of Health on 12/02/2024 at 8:28 PM. The findings include: The Facility's Policy and Procedure titled Abuse and Neglect Policy with a revised dated 08/20/2024 documented that it is the policy of the facility to assure residents are free from abuse and neglect, including involuntary seclusion. Furthermore, residents will not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, family members, legal guardians or outside members of the community. 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.Resident #3 was admitted to the facility with diagnoses including Right Humerus Fracture and Diabetes Mellitus. The Minimum Data Set (a resident assessment tool) dated 11/01/2024 documented that Resident #3's cognition was intact.Resident #4 admitted to facility with diagnoses including Opioid Dependence, Alcohol Substance Abuse and Pain Disorder. The Minimum Data Set (a resident assessment tool) dated 12/03/2024 documented Resident #4 was assessed with intact cognition.The Investigation Summary dated 12/04/2024 documented that Resident #4 reported to staff that on 12/02/2024 at approximately 7:12 AM, they and Resident #3 had an altercation, and that Resident #3 threw a chair on them hitting them on their back. Resident #4 was assessed with no redness, bruising or swelling. The skin was intact. Resident #4 denied pain at the time of incident. The Medical Doctor and family were notified. The investigation revealed that both residents had a disagreement because Resident #4's television remote control was changing Resident #3's television channel every time Resident #4 changed their television channel. Prior to the altercation, neither resident reported their concerns to the staff. As per video footage investigation, Resident #3 became frustrated and tossed a chair down the hallway towards Resident #4's direction. Resident #4 caught the chair at the floor level with their hand and dragged it down the hall. The facility's investigation concluded that there was no reasonable cause to believe abuse has occurred. To prevent reoccurrence, the maintenance checked all television remote to ensure that they were not synching to roommates, Resident #4 was transferred to different unit, staff were in-service on abuse, neglect and mistreatment and the policy on abuse was reviewed with no revision. A Webform Submission from the Nursing Home Facility Incident Report showed that the facility submitted their initial incident report to New York State Department of Health on 12/02/2024 at 8:28 PM.Previous Director of Nursing who investigated the incident was no longer employed in the facility.During an interview on 07/17/2024 at 2:30 PM, the Administrator stated that they were notified of the incident on 12/02/2024 at 8:00 AM and that they reported the incident to the New York State Department of Health on 12/02/2024 at 8:28 PM. The Administrator stated that they are aware that any form of allegation of abuse must be reported within 2-hour to New York State Department of Health. The Administrator stated that they reported the incident a little late because they reviewed the video footage and got busy investigating the incident. 10 NYCRR 415.4 (b)(1)(ii)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during an abbreviated survey (NY00359953), the facility did not ensure that each resident received adequate supervision to prevent an elopement. This was evident for one (1) out of two (2) residents (Resident #1) sampled for elopement. Specifically, the facility Elopement Incident Timeline dated 11/08/2024 documented that the surveillance video footage showed at 2:46 PM on 11/07/2024 Resident #1 exited the facility grounds. Resident #1 was wearing a wander guard on their left ankle at the time they left the facility, and the wander guard alarm system did not activate. Facility staff became aware between 3:20 PM and 3:58 PM that Resident #1 was missing from the facility. Resident #1 was located by a facility staff at 10:45 PM on 11/07/2024 walking towards their home. Resident #1 had no injury but was transferred to the hospital on [DATE] at 12:18 AM for evaluation. The findings include:The facility's Policy and Procedure titled Resident Elopement Prevention revised 09/2024 documented that it is the policy of the facility to provide residents with a safe and secure environment and protected from harm. The facility will make every possible effort to identify residents who have the potential for elopement. If a resident is found missing, the facility will ensure immediate implementation of missing resident search procedures.The facility's Policy and Procedure titled Front Desk effective dated 10/2023 documented the purpose is to ensure the safety and security of all residents, staff, and visitors by enforcing standardized protocols at the facility's front desk. This includes proper sign-in procedures, verification of authorized visitors, and monitoring of residents with [NAME] guard alerts. The Reception/Security watch for residents on the list approaching the exit unescorted. Resident #1 was admitted to the facility with diagnoses including Alcohol abuse, Hypertension, and Dementia.The Minimum Data Set (an assessment tool) dated 10/17/2024 documented Resident #1 had a Brief Interview of Mental Status (used to determine attention, orientation, and ability to recall information) score of 8 associated with moderately impaired cognition. Resident #1 ambulates independently.An Elopement Risk assessment dated [DATE] documented that Resident #1 was identified at risk for elopement due to Resident #1 verbalizing that they want to leave the facility and wandering behavior. An Elopement Care Plan dated 10/12/2024 documented that Resident #1 was unaware of safety needs and had a history of wandering behavior in the community. A wander guard was placed on Resident #1's left ankle.There was no documented evidence of a monitoring sheet for Resident #1.A nursing progress note dated 11/07/2024 at 8:52 PM by Registered Nursing #1, documented that Resident #1's adult child visited at 3:20 PM and Resident #1 was not in their room. A nursing progress note dated 11/07/2024 at 10:56 PM by Registered Nursing #2, documented that they heard Code Orange alarmed at 3:58 PM due to Resident #1 being missing from the third floor and could not be found. 911 and the Director of Nursing was notified. Resident #1 was later found in the street and was brought back to facility. Resident #1 was transferred to hospital for evaluation. An Elopement Incident Timeline dated 11/08/2024 documented at 3:20 PM Resident #1's adult child arrived at the facility and Resident #1 was not in their room. The staff were notified and immediately searched the building. At approximately 3:20 PM to 3:58 PM the search continued to common areas where Resident #1 frequently goes. At approximately 3:58 PM, the elopement protocol was formally activated. The police were notified, and local transportation were contacted to aid in the search. At approximately 4:00 PM a headcount was completed for all residents. At approximately 4:20 PM the surveillance footage reviewed and confirmed that Resident #1 exited the facility at 2:46 PM. At approximately 4:40 PM, the Department of Health was notified. At approximately 5:50 PM, it was discovered that the entrance door alarm was malfunctioning. At approximately 10:45 PM, Resident #1 was found approximately 10 minutes from their home by facility staff. At approximately 11:13 PM, Resident #1 was returned to facility and was assessed with no injuries or medical concern. The family were notified and requested the resident be transferred to the hospital for further evaluation. The Medical Doctor was notified. The Investigation Summary dated 11/08/2024 documented based on the facility's investigation, Resident #1 had eloped. During an interview on 07/16/2025 at 1:33 PM, Certified Nursing Assistant #1 stated that Resident #1 was assigned to them on 11/07/2024 from 7:00 AM to 3:00 PM. Certified Nursing Assistant #1 stated that Resident #1 had a wander guard on their left ankle and was being monitored on the unit. Certified Nursing Assistant #1 stated that they do not have a monitoring log - they just visually check on Resident #1 because the resident was at risk for elopement and was wearing a wander guard. Certified Nursing Assistant #1 stated that Resident #1 did not verbalize wanting to leave the facility and did not exhibit any unusual