

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335273	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2024
NAME OF PROVIDER OR SUPPLIER Verrazano Nursing and Post-Acute Center		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Castleton Avenue Staten Island, NY 10301	

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>49081</p> <p>Based on observation, interviews and record review conducted during an Abbreviated Survey (NY 00342773), the facility did not ensure a resident's right to be free from physical abuse by nursing home staff. This was evident for one out of four residents sampled for abuse (Resident #1). Specifically, on 05/20/24 at 5:04 pm in the dining room, the facility's video footage showed Resident #1 threw a cup of water on Certified Nursing Assistant #1's back and Certified Nursing Assistant #1 turned around and slapped Resident #1 with an open right hand on the back of Resident #1's neck. The Registered Nurse Supervisor #2 assessed Resident #1 and there was no visible injury, no redness or discoloration to the skin. Resident #1 did not complain of pain. On 05/20/24 at approximately 7:10 pm, the Administrator called New York City Law Enforcement and New York City Police Officers arrived at the facility.</p> <p>The findings are:</p> <p>The Facility's Policy on Abuse Prevention reviewed 10/22, documented residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation by anyone in this facility. The facility has developed policies and procedures to prohibit and prevent abuse, neglect, exploitation of residents and misappropriation of resident property which include the following components: Screening, Training, Prevention, Identification, Investigation, Protection and Reporting/response.</p> <p>Resident #1 was admitted to the facility with diagnoses including Non-Alzheimer's Disease, Bipolar Disorder and Major Depressive Disorder.</p> <p>Minimum Data Set (an assessment tool) dated 02/02/24, documented Resident #1 had a Brief Interview for Mental Status score of 11 out of 15, indicating moderately cognitively impaired.</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 Accident/ Incident report documented abuse occurred on 05/20/24 at 5:00 pm, Certified Nursing Assistant #2 reported to the facility's Scheduler that Certified Nursing Assistant #1 and Resident #1 were yelling loud in the dining room. The Scheduler informed the Director of Nursing. The Registered Nurse Supervisor #1 and the Administrator were informed and initiated an investigation. The Facility video footage was viewed and showed Certified Nursing Assistant #1 slapped Resident #1 at the back of their neck. Statements from Certified Nursing Assistant #1 and #2 documented that Resident #1 got irritated when the television was turned off and unplugged by Certified Nursing Assistant #1. The Registered Nurse Supervisor #2 assessed Resident #1 and there was no visible injury, no redness or discoloration to the skin. Resident #1 did not complain of pain. The New York State Law Enforcement was called by the Administrator on 05/20/24 and arrived at approximately 7:10 pm. The New York City Police Officers reviewed the facility's video footage and decided the incident was considered harassment and Certified Nursing Assistant #1 would not be arrested.</p> <p>During an interview on 05/29/24 at 4:30 pm, Certified Nursing Assistant #1 denied touching or hitting Resident #1 and stated it was Resident #1 who threw water on them. The Certified Nursing Assistant #1 stated they were told by the New York City Police Officer not to return to the facility.</p> <p>During an interview on 05/29/24 at 11:40 am, Certified Nursing Assistant #2 stated on 05/20/24 at approximately 5:00 pm, Certified Nursing Assistant #1 and Resident #1 were yelling in the dining room. Certified Nursing Assistant #2 stated Resident #1 got upset when the television was unplugged by Certified Nursing Assistant #1. The Certified Nursing Assistant #2 stated they did not witness when Resident #1 threw water on Certified Nursing Assistant #1 in the dining room. The Certified Nursing Assistant #2 stated they observed Resident #1 holding a fork but did not see any hitting. The Certified Nursing Assistant #1 took the fork from Resident #1's hand. Certified Nursing Assistant #2 said Certified Nursing Assistant #1 wheeled Resident #1 to their room. Certified Nursing Assistant #2 stated they heard Resident #1 yelling and they call the Scheduler to report the yelling.</p> <p>During an interview on 05/30/24 at 12:13 pm, the Director of Nursing stated on 05/20/24 at approximately 05:15 pm, they were called at home and informed by the Scheduler that Resident #1 and Certified Nursing Assistant #1 were yelling. The Director of Nursing called the Administrator and the Registered Nurse Supervisor #1 who were in the facility. The Director of Nursing stated they reviewed the video footage and concluded that Certified Nursing Assistant #1 slapped Resident #1's back of their neck. The Director of Nursing stated Resident #1 got upset when the television was turned off by Certified Nursing Assistant #1. The Director of Nursing stated it was their facility routine to turned off the television during mealtime to prevent distraction while eating in the dining room. The Director of Nursing stated they reported the Certified Nursing Assistant #1 to their agency and informed that Certified Nursing Assistant #1 cannot return to the facility. The Director of Nursing concluded in their investigation that the cause for the incident was identified and there was evidence that an abuse occurred between Certified Nursing Assistant #1 and Resident #1. The Director of Nursing stated Resident #1 was assessed and there were no signs of emotional distress.</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 05/30/24 at 1:01 pm, Administrator stated they were notified by the Director of Nursing on 05/20/24 at approximately 5:25 pm and immediately went to the nursing unit with Registered Nurse Supervisor #1. The Administrator stated that Resident #1 refused to go to the hospital for further evaluation. The local law enforcement was called and reviewed the video footage and revealed Certified Nursing Assistant #1 slapped Resident #1 with an open right hand on the back of Resident #1's neck. The Administrator stated the New York City Law Enforcement considered the act as harassment and the Certified Nursing Assistant #1 was sent home and removed from the schedule. The Administrator acknowledge the facility's concluded that an abuse occurred between Certified Nursing Assistant #1 and Resident #1.</p> <p>10 NYCRR 415.4(b)(1)(i)</p>