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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335321 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/20/2025 |
| NAME OF PROVIDER OR SUPPLIER Split Rock Rehabilitation and Health Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 3525 Baychester Ave Bronx, NY 10466 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <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>Based on record review and interviews conducted during an Abbreviated Survey (NY00373021), the facility failed to report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This was evident in one (1) out of five (5) residents sampled (Resident #1). Specifically, on 02/26/2025 at approximately 3:30 PM, Resident #1 reported to Social Worker #1 that they were missing seven thousand dollars, and that Certified Nursing Assistant #1 took their money during care. The facility completed their investigation on 03/11/2025 and submitted the findings to New York State Department of Health on 03/11/2025 at 4:23 PM. The facility did not complete and submit their investigation report within 5 working days to New York State Department of Health.</p> <p>The findings include:</p> <p>The Facility's Policy and Procedure on Abuse, Neglect, Mistreatment and Exploitation dated 03/11/2024 documented the facility will report the results of all reportable investigations to the State Survey Agency, Law Enforcement if needed and the follow up report to the State Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Resident #1 was admitted to the facility with diagnoses including Multiple Sclerosis and Adult Failure to Thrive.</p> <p>The Minimum Data Set (an assessment tool) dated 12/21/2024 documented Resident #1 was assessed with intact cognition.</p> <p>The Resident/Family Complaint/Grievance Form dated 02/26/2025 (no time) documented Resident #1 reported that their seven thousand dollars was missing, and that Certified Nursing Assistant #1 took the money when they were provided care to them.</p> <p>The Facility Summary of Investigation dated 03/11/2025 documented Certified Nursing Assistant #1 was not familiar with Resident #1. The work schedule for Certified Nursing Assistant #1 confirmed that they did not work on Resident #1 unit during the month of January 2025 and at no time was assigned to Resident #1. The facility concluded that there was no corroborating evidence to support Resident #1's claim of missing money or alleged involvement of Certified Nursing Assistant #1. The facility staff were educated on abuse prevention and misappropriation of property.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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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>A Webform Submission from the Nursing Home Facility Incident Report showed that the facility submitted their completed investigation to New York State Department of Health on 03/11/2025 at 4:23 PM.</p> <p>During an interview on 05/20/2025 at 2:00 PM, the Director of Nursing stated they were not aware that the follow up report of investigation must be submitted within five business days to the Department of Health. The Director of Nursing stated they submitted the completed investigation on 03/11/2025 at 4:23 PM which was considered late submission.</p> <p>During an interview on 05/20/2025 at 3:00 PM, the Administrator stated that the completed investigation should have been submitted to the Department of Health within five business days. The Administrator stated that they were aware that they submitted the investigation late.</p> <p>10 NYCRR 415.4 (b)(1)(ii)</p> | | |