STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335334	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Riverside	150 Riverside Drive New York, NY 10024

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50894 Resident #392 Based on record review and interviews conducted during the Recertification and Abbreviated (NY00338415) Survey from 11/13/2024 to 11/20/2024, the facility failed to ensure that a resident was free from physical abuse. This was evident in 1 (Resident #392) of 7 residents reviewed for abuse out of 39 total sampled residents. Specifically, on 04/06/2024 at approximately 06:30 AM, a video recording device in Resident #392's room recorded Certified Nursing Assistant #12 grabbing and hitting Resident #392 on the hands and arms. The findings are: The facility policy titled Abuse Reporting with a revision date of 09/26/2024 documented that the facility will not condone resident abuse by anyone, including staff members, other residents, consultants, volunteers, and staff of other agencies serving the resident, resident representatives, family members, legal guardians, sponsors, friends, or other individuals. The Incident Report dated 04/07/2024 documented that on 04/07/2024 at approximately 11:45 AM, Resident #392's wife reported to Assistant Director of Nursing #1 that they had placed a video recording device in Resident #392's room. Resident #392's wife reported that they had reviewed footage from the recording device and observed Certified Nursing Assistant #12 roughly handling Resident #392 on 04/06/2024 at approximately 06:30 AM. The Incident Report documents that Assistant Director #1 reviewed the footage and confirmed that Certified Nursing Assistant #12 rough handled Resident #392 on 04/06/2024 at approximately 06:30 AM. Following review of the footage, Assistant Director of Nursing #1 assessed Resident #392. Resident #392 did not show signs of distress or being in pain. Resident #392 was observed to have purplish discolorations on: the right dorsal hand measuring 1 cm x 1cm, the left hand measuring 1.2 cm x 1cm, and the right arm measuring 0.5 cm x 0.5 cm. The skin remained intact with no swelling or edema observed. The Incident Report concluded that the rough handling of Resident #392 by Certified Nursing Assistant #12 was consistent with abuse. The Employee Disciplinary Notice dated 04/08/2024 documents that Certified Nursing Assistant #12 was terminated on 04/08/2024 related to the physical abuse incident against Resident #392 on 04/06/2024. The Employee Disciplinary Notice documented that Certified Nursing Assistant #12 refused to provide the facility with a statement related to the incident. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor made multiple attempts to reach Certified Nursing Assistant #12 via phone for a between 11/13/2024 and 11/20/2024 but was unable to reach Certified Nursing Assistant #12. Resident #392 had diagnoses including Non-Alzheimer's Dementia, muscle weakness, and speech and language deficits following Cerebrovascular disease. The Quarterly Minimum Data Set assessment dated [DATE] documented that Resident #392 had severely impaired cognition. A Comprehensive Care Plan dated 08/29/2023 and revised on 10/01/2024 documented that Resident #392 was at risk for abuse related to cognitive impairment and dependence on others for activities of daily living care. The facility interventions documented were to provide one to one visits with the resident, investigate all allegations of abuse promptly, and assess the resident for signs and symptoms of abuse such as bruising, behavior changes, weight loss, and changes in psychosocial status, and to report any signs to appropriate resources. A Psychiatry Progress Note dated 04/08/2024 documented that Resident #392 was evaluated by Psychiatry following the abuse incident on 04/06/2024. The Psychiatry note documented that Resident #392 was confused, smiling, and in no apparent distress. Resident #392 was unable to provide information related to the incident or interactions with staff. On 11/19/2024 at 02:24 PM, Assistant Director of Nursing #1 was interviewed and stated that they received the initial abuse allegation from Resident #392's wife. They stated that they reviewed the video footage of the incident which showed that Certified Nursing Assistant #12 had handled Resident #392 roughly. They stated that following the review of the footage, they notified the facility's doctor, the Director of Nursing, the Administrator, and the New York Police Department. Assistant Director of Nursing #1 stated that they assessed the resident and observed purplish discolorations on Resident #392's right hand, left hand, and right arm. Assistant Director of Nursing #1 stated that the Director of Nursing then took over the investigation to report it to the Department of Health and to discipline Certified Nursing Assistant #12. On 11/19/2024 at 11:08 AM, the Director of Nursing was interviewed and stated that the Assistant Director of Nursing #1 received the allegation of Certified Nursing Assistant #12 abusing Resident #392 by Resident 392's wife on 04/07/2024. Assistant Director of Nursing #1 assessed the resident and notified the Director of Nursing of the incident. The New York Police Department was notified of the incident and Resident #392's wife declined to press charges against Certified Nursing Assistant #12. Certified Nursing Assistant #12 was not in the facility when the facility became aware of the incident. Certified Nursing Assistant #12 was removed from the schedule and reported to the facility on [DATE] to be interviewed by the Director of Nursing regarding the reported incident. The Director of Nursing stated that Certified Nursing Assistant #12 stated that they had been trying to provide care to Resident #392 and that the resident fought against her. The Director of Nursing stated that they showed Certified Nursing Assistant #12 the video footage of the incident and Certified Nursing Assistant #12 refused to provide a written statement related to the incident. The Director of Nursing stated that Certified Nursing Assistant #12 was then terminated, and that their actions violated the facility's abuse prevention policies. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/2024 at 12:10 PM, the Administrator was interviewed and stated that they were informed by the Director of Nursing of the abuse investigation related to Resident #392 and Certified Nursing Assistant #12. They stated that the Director of Nursing completed the investigation and reported it to the Department of Health. The Administrator stated that the abuse incident should not have occurred but that they felt like the facility did a good job in completing the ensuing investigation. 10 NYCRR 415.4(b)(1)(i)