STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335372	A. Building B. Wing	11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Vanderbilt Rehabilitation and Care Center, Inc	135 Vanderbilt Ave Staten Island, NY 10304

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** 39365 Based on observations, record review, and interviews conducted during an abbreviated survey (NY00321932), the facility failed to protect a resident's right to be free from physical abuse by nursing home staff. This was evident for 1 of 7 residents reviewed for abuse (Resident #1). Specifically, a review of the facility surveillance camera revealed that on 08/10/2023 at 12:16 AM, Resident #1 exhibited agitation and physical aggression. Resident #1 struggled with CNA #1 and stumbled on the floor. While Resident #1 was on the floor, CNA #1 held Resident #1's arms and their left knee rested on Resident #1's left hip preventing Resident #1 from getting up and as a means to control Resident #1's behavior. A review of the camera also showed at 12:22 AM that CNA #1 held Resident #1 against the wall when Resident #1 chased CNA #1 in the hallway. Cross reference: F604 - Right to be Free from Physical Restraints The findings are: The Facility's Policy titled Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Residents' Property with the last review date of 10/24/2022 documented that it is the policy of the facility that the resident has the right to be free from verbal, sexual, and physical and mental abuse, corporal punishment and involuntary seclusion. Resident #1 had diagnoses of Intellectual Disability due to [NAME]-Will Syndrome, Disorganized Schizophrenia, and Depression. The Minimum Data Set (MDS, a resident assessment tool) dated 06/19/2023 documented that Resident #1 had severely impaired cognition. A Comprehensive Care Plan (CCP) for potential for abuse was initiated on 02/03/2023. The CCP documented that when Resident #1 gets angry, they are noted to throw things at people. The interventions included encouraging the resident to voice concerns to staff, providing support, Social Worker visits, and room change. (continued on next page)

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

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nurse's Note by Registered Nurse Supervisor #1 (RNS #1) dated 08/10/2023 at 1:02 AM documented Resident #1 was noted with increased anxiety, agitation, and was striking out at staff. They were redirected with no effect. Resident #1 threw any object they could get their hands on. The Medical Doctor (MD) was notified and ordered to send Resident #1 to the Psychiatric emergency room (ER) for evaluation. The facility's Internal Investigation dated 08/11/2023 documented that the Human Resources Director (HRD) reviewed the facility surveillance camera and noted that on 08/09/2023 at 12:19 AM, Resident #1 and CNA #1 were in an altercation at the nursing station. The facility investigation documented that the camera clearly showed that CNA #1 slapped Resident #1 across the face in an attempt to control Resident #1's aggressive behavior. CNA #1 wrestled with Resident #1 to the floor and CNA #1 held Resident #1 down with both arms. The facility concluded that abuse had occurred. The facility's video surveillance was reviewed with the Administrator and Director of Nursing (DON) on 08/22/2023 at 10:54 AM. Camera #1 showed on 08/10/2023 at 12:16 AM, Resident #1 was in their wheelchair sitting next to the nurses' station, with a shredder box, mobile sphygmomanometer, and linen cart lying on the floor. At 12:17 AM, Resident #1 stood up from their wheelchair, went in front of the nurses' station, and threw punches at CNA #1. Resident #1 continued to throw punches at CNA #1 while attempting to grab the computer monitor, printer, fan, and other items from the nursing station. CNA #1 tried to stop Resident #1 from taking the equipment by holding onto Resident #1's hands and blocking Resident #1's punches. This continued for 2 minutes. From 12:18 AM to 12:21 AM, Resident #1 continued throwing punches at CNA #1 as CNA #1 continued to prevent (holding Resident #1's hands and blocking punches) Resident #1 from pulling down the equipment from the desk at nursing station. Resident #1 tried to bite CNA #1's hand and CNA #1 pushed Resident #1's left cheek with their right hand. Resident #1 tried to enter the nursing station where CNA #1 was. CNA #1 then rushed towards Resident #1 and blocked Resident #1 by holding onto Resident #1's hands to prevent Resident #1 from entering the nursing station. Resident #1 and CNA #1 struggled backwards into the hallway and Resident #1 stumbled to the floor. While Resident #1 was on the floor, CNA #1 held Resident #1's arms, and CNA #1's left knee rested on Resident #1's left hip to prevent Resident #1 from getting up. LPN #2 arrived on the unit and made a gesture to CNA #1. CNA #1 then released Resident #1. Resident #1 got up independently from the floor and chased CNA #1. Camera 2 showed that Resident #1 caught up to CNA #1. CNA #1 held Resident #1 against the wall in the hallway. LPN #2 made a hand gesture to CNA #1 to let go of Resident #1. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/22/2023 at 3:48 PM, CNA #1 stated they arrived at the unit at around 11:00 PM and observed Resident #1 sitting in their wheelchair by the nursing station. CNA #1 stated that Resident #1 got up from the wheelchair and knocked down the shredder box and other items and tried to remove other items from the wall. Resident #1 continued to remove items from the wall and came over to the nursing station and tried to knock over the computer, printer, and fan that was attached to the wall. CNA #1 stated that their intention was to prevent Resident #1 from injuring themselves. CNA #1 stated that they tried to hold Resident #1's hands to prevent them from pulling the cords. CNA #1 stated that Resident #1 spat and tried to bite CNA #1's hand. CNA #1 stated they moved their hand toward the Resident's mouth with no intention to hit. CNA #1 stated they did not hit Resident #1 in the face. CNA #1 stated that when Resident #1 tried to enter the nursing station, they blocked them from coming and held their hands. Resident #1 moved backward and fell . CNA #1 stated they held Resident #1 on the floor to prevent them from injuring themselves. CNA #1 stated that when a nurse from another floor came, they released the Resident and walked away. CNA #1 stated that Resident #1, who was still agitated, followed them in the hallway. CNA #1 stated that they held Resident #1 by the wall to prevent Resident #1 from going to other residents' rooms. During an interview on 08/23/2023 at 1:00 PM, the Director of Nursing (DON) stated they were made aware of the incident on 08/11/2023 at 2:00 PM. The DON stated they viewed the camera with the Administrator, saw Resident #1 hit CNA #1 a few times, and that CNA #1 slapped Resident #1. The DON stated they observed in the camera that Resident #1 fell on the floor, and CNA #1 held Resident #1. Resident #1 got up and chased CNA #1. CNA #1 stopped walking and held the resident to the wall. The DON stated that CNA #1's action constituted abuse and restraint. During an interview on 11/09/2023 at 12:50 PM, the Administrator stated they reviewed the camera on 08/11/2023 at around 2:00 PM and came across the incident where they observed CNA #1 slapped Resident #1. The camera review also showed CNA #1 restrained Resident #1 on the floor. The Administrator stated that CNA #1's action was considered abuse. The Administrator stated they had overseen the investigation and made sure that CNA #1 was terminated, and that other necessary disciplinary actions were taken. 415.11(c)(2)(i-iii)

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39365 Based on observations, record review, and interviews conducted during an abbreviated survey (NY00321932), the facility failed to protect a resident's right to be free from physical restraint. This was evident for 1 of 7 residents reviewed for abuse (Resident #1). Specifically, a review of the facility surveillance camera revealed that on 08/10/2023 at 12:16 AM, Resident #1 exhibited agitation and physical aggression. Resident #1 struggled with CNA #1 and stumbled on the floor. While Resident #1 was on the floor, CNA #1 held Resident #1's arm and their left knee rested on Resident #1's left hip preventing Resident #1 from getting up. A review of the camera also showed at 12:22 AM that CNA #1 held Resident #1 against the wall when Resident #1 chased CNA #1 in the hallway. Cross Reference: F600 - Free from Abuse and Neglect The findings are: The Facility's Policy titled Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Residents' Property with the last review date of 10/24/2022 documented that it is the policy of the facility that the resident has the right to be free from verbal, sexual, and physical and mental abuse, corporal punishment and involuntary seclusion. The Facility's Policy titled Restraint Reduction/Elimination dated 06/2023 documented it is the policy of the facility to promote and maintain the resident's highest practicable well-being in an environment that limits the use of restraints to circumstances that warrant use as related to a resident's specific medical symptoms and systematically review restraint use to ensure that the least restrictive device is utilized with ongoing assessments for the reduction/elimination of the restraint. Resident #1 had diagnoses of Intellectual Disability due to [NAME]-Will Syndrome, Disorganized Schizophrenia, and Depression. The Minimum Data Set (MDS, a resident assessment tool) dated 06/19/2023 documented that Resident #1 had severely impaired cognition. A Comprehensive Care Plan (CCP) for potential for abuse was initiated on 02/03/2023. The CCP documented that when Resident #1 gets angry, they are noted to throw things at people. The interventions included encouraging the resident to voice concerns to staff, providing support, Social Worker visits, and room change. A Nurse's Note by Registered Nurse Supervisor #1 (RNS #1) dated 08/10/2023 at 1:02 AM documented Resident #1 was noted with increased anxiety, agitation, and was striking out at staff. They were redirected with no effect. Resident #1 threw any object they could get their hands on. The Medical Doctor (MD) was notified and ordered to send Resident #1 to Psychiatric emergency room (ER) for evaluation. (continued on next page)

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Internal Investigation dated 08/11/2023 documented that the Human Resources Director (HRD) reviewed the facility surveillance camera and noted that on 08/09/2023 at 12:19 AM, Resident #1 and CNA #1 were in an altercation at the nursing station. The facility investigation documented that the camera clearly showed that CNA #1 slapped Resident #1 across the face on an attempt to control Resident #1's aggressive behavior. CNA #1 wrestled with Resident #1 to the floor and CNA #1 held Resident #1 down with both arms. The facility concluded that abuse had occurred. The facility's video surveillance was reviewed with the Administrator and Director of Nursing (DON) on 08/22/2023 at 10:54 AM. Camera #1 showed on 08/10/2023 at 12:16 AM, Resident #1 was in their wheelchair sitting next to the nurses' station, with shredder box, mobile sphygmomanometer, and linen cart lying on the floor. At 12:17 AM, Resident #1 stood up from their wheelchair, went in front of the nurses' station, and threw punches at CNA #1. Resident #1 continued to throw punches at CNA #1 while attempting to grab the computer monitor, printer, fan, and other items from the nursing station. CNA #1 tried to stop Resident #1 from taking the equipment by holding onto Resident #1's hands and blocking Resident #1's punches. This continued for 2 minutes. From 12:18 AM to 12:21 AM, Resident #1 continued throwing punches at CNA #1 as CNA #1 continued to prevent (holding Resident #1's hands and blocking punches) Resident #1 from pulling down the equipment from the desk at nursing station. Resident #1 tried to bite CNA #1's hand and CNA #1 pushed Resident #1's left cheek with their right hand. Resident #1 tried to enter the nursing station where CNA #1 was. CNA #1 then rushed towards Resident #1 and blocked Resident #1 by holding onto Resident #1's hands to prevent Resident #1 from entering the nursing station. Resident #1 and CNA #1 struggled backwards into the hallway and Resident #1 stumbled to the floor. While Resident #1 was on the floor, CNA #1 held Resident #1's left arm, and CNA #1's left knee rested on Resident #1's left hip to prevent Resident #1 from getting up. LPN #2 arrived on the unit and made a gesture to CNA #1. CNA #1 then released Resident #1. Resident #1 got up independently from the floor and chased CNA #1. Camera 2 showed that Resident #1 caught up to CNA #1. CNA #1 held Resident #1 against the wall in the hallway. LPN #2 made a hand gesture to CNA #1 to let go of Resident #1. During an interview on 08/22/2023 at 3:48 PM, CNA #1 stated that they arrived at the unit at around 11:00 PM and observed Resident #1 sitting in their wheelchair by the nursing station. CNA #1 stated that Resident #1 got up from the wheelchair and knocked down the shredder box and other items and tried to remove other items from the wall. Resident #1 continued to remove items from the wall and came over to the nursing station and tried to knock over the computer, printer, and fan that was attached to the wall. CNA #1 stated that their intention was to prevent Resident #1 from injuring themselves. CNA #1 stated that they tried to hold Resident #1's hands to prevent them from pulling the cords. CNA #1 stated that Resident #1 spat and tried to bite CNA #1's hand. CNA #1 stated they moved their hand toward the Resident's mouth with no intention to hit. CNA #1 stated they did not hit Resident #1 in the face. CNA #1 stated that when Resident #1 tried to enter the nursing station, they blocked them from coming and held their hands. Resident #1 moved backwards and fell . CNA #1 stated they held Resident #1 on the floor to prevent them from injuring themselves. CNA #1 stated that when a nurse from another floor came, they released the Resident and walked away. CNA #1 stated that Resident #1 who was still agitated followed them in the hallway. CNA #1 stated that they held Resident #1 by the wall to prevent Resident #1 from going to other residents' rooms. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/22/2023 at 5:20 PM, LPN #1 stated that at approximately after 12:00 AM, CNA #2 called them and stated that Resident #1 was throwing items around. LPN #1 went to the nurses' station and observed Resident #1 pushing the computer and printer. CNA #1 was at the nurses' station and was attempting to stop Resident #1. LPN #1 stated they went to the medication room to call the RNS. LPN #1 got LPN #2 on the phone and asked them to page the RNS. After speaking with LPN #2, LPN #1 stated they came out of the medication room and observed Resident #1 on the floor with CNA #1 holding the Resident down. During an interview on 08/22/2023 at 5:10 PM, LPN #2 stated that they were assigned on a different unit when they received a phone call from LPN #1 about the incident. LPN #2 stated that they called the RNS and responded to the unit. Upon arrival, they observed CNA #1 restraining Resident #1 on the floor. LPN #2 stated they told CNA #1 to release Resident #1. CNA #1 let Resident #1 go but Resident started chasing CNA #1. LPN #2 followed Resident #1 and brought them to the nurses' station where Resident calmed down. During an interview on 08/23/2023 at 1:00 PM the Director of Nursing (DON) stated they were made aware of the incident on 08/11/2023 at 2:00 PM. The DON stated they viewed the camera with the Administrator saw Resident #1 hit CNA #1 a few times, and that CNA #1 slapped Resident #1. The DON stated they observed in the camera that Resident #1 fell on the floor and CNA #1 held Resident #1. Resident #1 got up and chased CNA #1. CNA #1 stopped walking and held the resident to the wall. The DON stated that CNA #1's action constituted abuse and restraint. The DON stated that staff should not restrain any resident. In a situation when a resident becomes aggressive, staff were taught to step back and call for help. During an interview on 11/09/2023 at 12:50 PM, the Administrator stated they reviewed the camera on 08/11/2023 at around 2:00 PM and came across the incident where they observed CNA #1 slapped Resident #1. The camera review also showed CNA #1 restrained Resident #1 on the floor. The Administrator stated that CNA #1's action was considered abuse. The Administrator stated they had overseen the investigation and made sure that CNA #1 was terminated, and that other necessary disciplinary actions were taken. 10 NYCRR 415.4 (a) (2-7)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39365 Based on record review and interviews conducted during an abbreviated survey (NY00321932), the facility failed to ensure that each resident received the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychological well-being, in accordance with the comprehensive assessment and plan of care. This was evident in 1 of 7 residents reviewed for abuse (Resident #1). Specifically, Resident #1 exhibited several incidents of aggressive behavior towards staff and other residents. The facility did not evaluate the effectiveness of the interventions to address Resident #1's aggression. The findings are: The facility's Policy titled Behavioral Health Services with effective date of 10/2022 stated that each resident must receive, and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychological well-being, in accordance with comprehensive assessment and plan of care. Resident #1 had diagnoses of Intellectual Disability due to [NAME]-Will Syndrome, Disorganized Schizophrenia, and Depression. The Minimum Data Set (MDS, a resident assessment tool) dated 06/19/2023 documented that Resident #1 had severely impaired cognition. The MDS did not document any behavioral symptom. A Comprehensive Care Plan (CCP) for behavior symptoms, physical and verbal abuse, was initiated on 06/11/2023. The CCP documented Resident #1 exhibits physically aggressive behavior toward staff / others. The facility interventions included identifying patterns of behavior, removing resident from situation triggering behavior, redirect negative behaviors, and to allow resident time to de-escalate when agitated. The CCP notes for behavior symptoms documented on 06/11/2023, Resident #1 grabbed a Certified Nursing Assistant's (CNA) neck and pulled the CNA's hair while CNA was trying to pick up Resident #1's socks on the floor. 07/25/2023, Resident #1 yelled and screamed at the laundry attendant about socks. Resident #1 also bit their right hand out of anger while screaming. On 08/09/2023, Resident #1 was noted hitting the pantry door with their elbow, pacing back and forth, and going in and out of other residents' room. On 08/10/2023, Resident was noted with increased anxiety and agitation characterized by striking out at staff, was also noted throwing objects. The CCP did not document individualized intervention related to Resident #1's behavior. There was no documented evidence that the interventions documented on the CCP was reviewed and evaluated after each incident of physical aggression. There was no additional intervention put in place to address Resident #1's aggressive behavior after 06/11/2023. A Physician Order dated 06/14/2023 documented Psychiatry Consult, Resident #1 was on Psychotropic therapy; Psychology consult due to aggressive behavior; and every 30-minute monitoring. A Nursing Assistant Clinical Accountability Record and assessment dated ,d+[DATE] documented fall and seizure precautions. There were no documented instructions to monitor Resident #1 for behavior and what to do if Resident #1 becomes physically aggressive. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Undated Resident Care Profile documented Resident #1 was at high risk for falls, Resident #1 was confused and resists care. There were no documented instructions for to monitor Resident #1 for behavior and what to do if the resident becomes physically aggressive. A Psychiatry Consult dated 08/11/2023 documented Resident #1's diagnosis of Disorganized Schizophrenia. Recommended to add Depakote 250 milligram (mg) every 8 hours, to increase Risperdal Consta to 37.5 mg every 2 weeks. During an interview on 11/09/2023 at 1:05 PM, the Director of Social Services (DSS) stated that they were Resident #1's Social Worker in 08/2023. DSS stated their role was to advocate for Resident #1 and communicate with their family and staff. DSS stated that they participated in interdisciplinary meetings where they discussed Resident #1's needs and behavior. DSS stated that it is Nursing Department's responsibility to launch a care plan and initiate interventions to prevent aggressive behavior. During an interview on 08/23/2023 at 11:00 AM, the Assistant Director of Nursing (ADNS) stated that nursing supervisors instruct medication nurses to tell CNAs who needs to be monitored for behavior, how to approach residents with behavior, and to immediately report any behavior changes to the supervisor. The ADNS stated that all these should be reflected in the CNA instructions. During an interview on 08/23/2023 at 1:00 PM the Director of Nursing (DON) #1 stated that staff were taught to step back and call for help when a resident becomes aggressive. The DON #1 stated that the CNA Accountability should specify what to do if the resident becomes aggressive. It is the unit manager's responsibility to update the CNA accountability and provide instructions for CNA on how to handle residents with difficult behavior. During an interview on 11/09/2023 at 2:30 PM, DON #3 stated that if a resident exhibits behavior, the unit manager is responsible for updating the CNA's accountability to reflect the behavior and what staff should do to prevent or decrease the behavior. DON #3 stated that the unit manager should update the care plan after each episode of aggressive behavior with new interventions and evaluate those interventions to see if it was effective. 415.12(f)(1)