STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335398	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sans Souci Rehabilitation and Nursing Center	115 Park Avenue Yonkers, NY 10703

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. 43478 Based on record review, and interviews conducted during an abbreviated survey (NY00334044), the facility did not ensure residents right to be free from abuse for 1 of 3 residents (Resident #3) reviewed for abuse. Specifically, on 2/21/24, Dietary Aide #15 was witnessed by a Certified Nurse Aide #14, verbally threatening Resident #3 and pulling on Resident #3 beaded necklace. Resident #3 written statement documented that a staff member entered his room and held them by the shirt and chest area and verbally threatened him. Resident #3 was assessed with no injuries. Facility Investigation concluded abuse occurred. Findings include: The facility policy, 'Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating' approved 6/3/24 documented that the facility process was to report abuse and thoroughly investigate all reports of abuse, and to provide a follow-up investigation report within 5 business days of the incident. Resident #3 was admitted with diagnoses which included osteoarthritis right shoulder, depression, and dementia. The Annual Minimum Data Set (resident assessment tool) dated 2/2/24 documented Resident #3 had moderately impaired cognition and no behavioral symptoms exhibited. Resident #3 required supervision with transfers to bed and ambulation. Resident required supervision for toiletting and hygiene and moderate assistance for bathing. Facility Investigation dated 2/21/24 documented on 2/21/24 at 8:16 pm, Resident #3 was overheard by Certified Nurse Aide #14 calling nurse, he is threatening me! Certified Nurse Aide #14's statement documented that the Certified Nurse Aide #14 witnessed Dietary Aide #15 pulling on Resident #3's beaded necklace and verbally threatening Resident #3. Per Resident #3's written statement, a kitchen staff member entered their room and held them by the shirt and chest area and verbally threatened them. The facility conclusion documented that verbal abuse occurred. (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	During an interview on 7/24/24 at 1:35 pm, Certified Nurse Aide #14 stated they were across the hall when they witnessed Dietary Aide #15 come out of the elevator and walk directly into Resident #3's room, they saw Resident #3 lying in bed, they heard Resident #3 scream Nurse, he's threatening me, help!, they saw Dietary Aide #15 grab Resident #3's beaded necklace which were around Resident #3's neck and pull the beads, and heard Dietary Aide #15 verbally threaten Resident #3. Certified Nurse Aide #14 stated they walked towards Resident #3's room as Dietary Aide #15 walked to the elevator. Certified Nurse Aide #14 stated they immediately reported the incident to the charge nurse. A telephone call was placed to Dietary Aide #15 on 7/24/24 at 1:48 pm. The service was out of service. During an interview with the facility Administrator on 7/24/24 at 2:30 pm, they stated they were made aware of the incident immediately, and an investigation was completed on 2/21/24. During a phone interview with the Director of nursing on 7/24/24 at 2:35 pm, they stated they were made aware of the incident immediately and an investigation was imitated. During an interview with Registered Nurse Supervisor #17 on 7/24/24 at 4:05 pm, they stated Certified Nurse Aide #14 reported the incident to the nurse, who reported to them, and they began the investigation immediately and notified the Director of Nursing and the facility Administrator and called the Police. The Dietary Aide #15 was asked to leave the building. Resident #3 was no longer at the facility at the time of the onsite visit. 10NYRCC 415.4(b)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50729 Based on observations, interviews and record review conducted during an abbreviated survey (NY00342153) the facility did not develop or implement a comprehensive person-centered care plan for Resident #1. Specifically, the heels of Resident #1 were not offloaded and or heel booties were not applied as per physician order and as per care plan. Findings are: The policy and procedure titled Pressure Injury Risk and assessment dated [DATE] documented the purpose of this procedure is to provide guidelines for the structured assessment and identification of residents at risk of developing new pressure injuries or worsening of existing pressure injuries. Multiple risk factors including but not limited to, impaired/decreased mobility and decreased functional ability, exposure of skin to urinary and fecal incontinence or other source of moisture. Once the assessment is conducted and risk factors are identified and characterized, a resident-centered care plan can be created to address the modifiable risks for pressure injuries. Resident # 1 was admitted on [DATE] with diagnoses, including but not limited to, Multiple Sclerosis, Non-Alzheimer Dementia, and Cerebrovascular Accident. The Annual Minimum Data Set, dated dated dated [DATE] documented Resident #1 had severe cognitive impairment, had no behaviors, was frequently incontinent of urine and always incontinent of bowel, had upper extremity impairment on one side, lower extremity impairment on both sides, had 1 stage 3 pressure ulcer present upon admission, a stage 4 pressure ulcer not present on admission and an infection of the foot also not present on admission. The care plan dated 7/7/23 titled Risk for Pressure Injury Development documented assistive device: to use foam positioning wedge when in bed in order to maintain side lying position and promote pressure relief and enhance comfort and elevate heels off of bed surface. The Physician Order dated 9/19/23 documented apply bilateral heel booties at all times every for prophylaxis and 10/24/23 assistive device to use foam positioning wedge when in bed in order to maintain side lying position and to promote pressure relief and enhance comfort (there was no directive included in this order). There was no documented evidence in the Treatment Administration Record on 7/23/24 prior to 2:00PM to indicate the heel booties had been applied on that day. Observation on 7/23/24 at 9:58 AM, 12:40 PM and 1:45 PM revealed Resident #1 lying curled up resting partially on their right side with a thin sheet covering. Resident #1 was leaning against a foam positioning wedge that was resting on the right 1/2 side rail. The foam position wedge was not placed to maintain side lying position as per physician order and/or care plan intervention. Resident #1's heels were resting on the mattress, there were no foot booties observed below the sheet. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interviewed on 7/23/24 at 1:03 PM Certified Nursing Assistant # 11stated they last changed Resident #1 at 9:30 AM. Certified Nursing Assistant #11 stated that this was their second day on the unit and they had not received report regarding care needs for Resident #1. Certified Nursing Assistant # 11 stated they did not know the resident was supposed to use a foam position wedge to maintain side lying position and was not aware the resident's heels should be offloaded and/or have heel booties on at all times. During interview on 7/23/24 at 1:40 PM Licensed Practical Nurse #1 stated Resident #1 was at risk for pressure ulcers and had a history of right toe and left hip pressure ulcers which had recently healed. Licensed Practical nurse #1 stated the residents should have heel booties or an offload pillow. Licensed Practical Nurse #1 stated it was difficult to off load the residents heels due to contractures. Licensed Practical Nurse #1 stated the nurses were responsible for putting the heel booties on Resident #1 and/or ensuring the heels were offloaded. Licensed Practical Nurse #1 stated they did not put the heel booties on that day. 10 NYCRR 415.11(c)(1)