

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335455	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/27/2025
NAME OF PROVIDER OR SUPPLIER  Carmel Richmond Healthcare and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 88 Old Town Road 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)
<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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39365</p> <p>Based on observation, record review, and interviews during an abbreviated survey, (NY00368833), the facility did not ensure the residents' right to be free from physical abuse. This was evidence for one out of six residents reviewed (Resident #1). Specifically, on 01/13/2025 at 07:18 PM, Licensed Practical Nurse #1 reported to Registered Nurse Supervisor #1, Certified Nursing Assistant #1 threw a cup of melted ice cream on Resident #1's. Registered Nurse Supervisor #1 assessed Resident #1 and observed a wet stain on the top of Resident #1's clothes.</p> <p>The findings are:</p> <p>The facility's Policy and Procedure entitled Abuse Prevention, dated 10/2022, documented it is the policy of the organization to ensure that all residents are free from abuse, neglect, misappropriation of resident property, and exploitation. The facility prohibits verbal, mental, sexual, and physical abuse and corporal punishment or involuntary seclusion by any staff, volunteer, or other resident.</p> <p>Resident #1 was admitted to the facility on [DATE], with the diagnosis of Dementia with behavior, Anxiety, and Major Depression.</p> <p>The Minimum Data Set (assessment tool), dated 11/27/2024, documented Resident #1 had a Brief Interview of Mental Status (used to determine attention, orientation, and ability to recall information) score of eight out of 15, indicating Resident #1 was moderately cognitive impaired.</p> <p>A Care Plan for Victimization was initiated on 04/03/2022, last updated on 09/14/2024, with interventions to involve Resident #1 in social activities, identifying triggers for behavior, and to use a calm approach by talking in a soothing manner to Resident #1.</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>A Nursing Note dated 01/13/2025 at 9:07 PM, written by Registered Nurse Supervisor #1 documented was informed at 7:18 PM, by Licensed Practical Nurse #1 Certified Nurse Assistant #1 threw melted ice cream into Resident #1's face. The Camera footage was reviewed, Resident #1 was seen at 7:06 PM taking a cup of melted ice cream off the medication cart. Certified Nursing Assistant #1 approached Resident #1, and Resident #1 threw the cup of melted ice cream at Certified Nursing Assistant #1. Certified Nursing Assistant #1 grabbed the cup and threw it into Resident #1's face. Certified Nursing Assistant #1 was removed from the floor. Resident #1 was assessed, denied pain, and no visible injuries were noted. Resident #1 denied emotional distress. The Assistant Director of Nursing was notified at 7:20 PM. The New York City Police were called at 7:55 PM. The Medical Doctor was made aware. Resident #1's family was notified. A psychiatry consultation was ordered.</p> <p>The facility's Investigative Summary dated 01/14/2024, documented on 01/13/2025 at 7:18 PM, Licensed Practical Nurse #1 reported that Certified Nursing Assistant #1 threw ice cream at Resident #1's face. Registered Nurse Supervisor #1 reviewed the video footage, and it was conformed that Certified Nursing Assistant #1 threw ice cream at Resident #1. Certified Nursing Assistant #1 was removed from the unit and was interviewed by the Assistant Director of Nursing over the phone with Registered Nurse Supervisor #1 present. Certified Nursing Assistant #1 stated Resident #1 called them racial words and threw ice cream in their face, and they threw it back at Resident #1. Certified Nursing Assistant #1 answered a repeated question, stating, Yes, I threw it back at Resident #1. It was a natural reaction. Certified Nursing Assistant #1 was suspended. The New York City Police were called at 7:55 PM and interviewed Resident #1, who could not recall the incident. The facility investigated and concluded that there is evidence to believe abuse regarding Resident #1 had occurred.</p> <p>A Tracking Quality Data for Improving Patient Safety dated 01/13/2025, documented on 01/13/2025 at 7:07 PM, Registered Nurse Supervisor #1 was notified by Licensed Practical Nurse #1 that Certified Nursing Assistant #1 threw melted ice cream into Resident #1's face.</p> <p>Surveillance video on the 6th Floor Nursing Station, dated 01/13/2025 at 7:07 PM, was reviewed with the Assistant Director of Nursing on 01/02/2025 at 10:45 AM. The video was recorded in real-time (military time) and revealed the following: On 01/13/2025 at 7:07 PM, Resident #1 approached the medication cart that was near the nursing station and took a covered orange cup from the cart and held the cup in their right hand. Certified Nurse Assistant #1 walked up close to Resident #1 with their back to the camera, and splashes of orange liquid got on Certified Nurse Assistant #1's left shoulder. Certified Nurse Assistant #1 raised their right hand, and splashes of orange liquid went toward Resident #1's neck area as Resident #1's head moved to the side. Resident #1 and Certified Nurse Assistant #1 went in opposite directions. Certified Nurse Assistant #2 and Certified Nurse Assistant #3 were in the hallway as the camera footage ended.</p> <p>During a telephone interview on 01/21/2025 at 12:50 PM, Certified Nursing Assistant #1 stated on 01/13/2025, after dinner, at around 7:00 PM, Resident #1 took an 8-ounce ice cream cup from the medication cart in front of the nursing station. Certified Nursing Assistant #1 stated they approached and told Resident #1 they cannot have the ice cream. Resident #1 used profanity and threw the cup with melted ice cream on their face, chest, and uniform. Certified Nursing Assistant #1 did not throw the ice cream back on Resident #1 but went away to clean their clothes.</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 a telephone interview on 01/21/2025 at 1:21 PM, Licensed Practical Nurse #1 stated they were sitting at the nursing station on 01/13/2025 after 7:00 PM (could not recall the exact time), Resident #1 was seen coming to the medication cart to get something. Licensed Practical Nurse #1 stated they told Resident #1 that they could not touch the nursing cart but Resident #1 ignored them. Licensed Practical Nurse #1 stated they saw Certified Nursing Assistant #1 approach Resident #1 and told Resident #1 that they could not touch the medication cart. Resident #1 grabbed the ice cream and threw it at Certified Nursing Assistant #1's chest, and it splashed on Certified Nursing Assistant #1's face and top. Licensed Practical Nurse #1 stated Certified Nursing Assistant #1 caught the cup on their chest and threw it at Resident #1, and Certified Nursing Assistant #1's right hand contacted Resident #1 upper shoulder. Licensed Practical Nurse #1 stated Certified Nursing Assistant #1 walked away quickly to the bathroom. Licensed Practical Nurse #1 stated Resident #1 walked away in the opposite direction. Licensed Practical Nurse #1 stated they yelled at Certified Nursing Assistant #1 that they could not do that and grabbed the phone to call Registered Nurse Supervisor #1, but Registered Nurse Supervisor #1 was coming out of the elevator, and they reported to them. Licensed Practical Nurse #1 stated Certified Nursing Assistant #1 was sent home. Licensed Practical Nurse #1 stated the police came to the facility, but they did not interview them.</p> <p>During telephone interviews on 01/21/2025 at 11:17 AM and 11:51 AM, Certified Nursing Assistant #2 and Certified Nursing Assistant #3 both stated they saw Resident #1 throw ice cream at Certified Nursing Assistant #1 but did not see if Certified Nursing Assistant #1 threw ice cream back at Resident #1 because they were behind Certified Nursing Assistant #1.</p> <p>During an in-person interview on 01/21/2025 at 3:28 PM, Registered Nurse Supervisor #1 stated on 01/13/2025 between 7:15 PM and 7:20 PM, Licensed Practical Nurse #1 informed them they observed Resident #1 taking ice cream from the medication cart and threw it at Certified Nursing Assistant #1 and Certified Nursing Assistant #1 grabbed the same cup and threw at Resident's #1 chest. Registered Nurse Supervisor #1 instructed Licensed Practical Nurse #1 to keep Certified Nursing Assistant #1 at the nursing station. Registered Nurse Supervisor #1 stated they assessed Resident #1 in their room and observed a wet stain on Resident #1's top. A full body assessment was done, and there was no redness or bruises. Resident #1 denied any pain or discomfort. Resident #1 had no recollection of the incident. Registered Nurse Supervisor #1 stated they called another Registered Nurse Supervisor #2 to safeguard Certified Nursing Assistant #1 in the nursing station while they went to call the Assistant Director of Nursing at 7:20 PM. Registered Nurse Supervisor #1 stated they went and took Certified Nursing Assistant #1 to the nursing office, and they were interviewed by the Assistant Director of Nursing. Registered Nurse Supervisor #1 stated Certified Nursing Assistant #1 admitted that they threw ice cream at Resident #1 as a reflex instinct reaction. Registered Nurse Supervisor #1 stated Certified Nursing Assistant #1 was suspended and escorted out of the facility. Registered Nurse Supervisor #1 stated the New York City Police were called at 7:55 PM, on arrival, Resident #1 was interviewed, and the police said that the report would be harassment. Registered Nurse Supervisor #1 stated that a Medical Doctor was called. Resident #1's the family was notified, and a Psychiatric consultation was ordered and done on the same day.</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 in-person interview on 01/21/2025 at 2:17 PM, the Assistant Director of Nursing stated they investigated the incident and concluded abuse occurred. The Assistant Director of Nursing stated Certified Nursing Assistant #1 did not write in their statement that they threw ice cream at Resident #1, but when they spoke with them over the phone on 01/13/2025 at 7:40 PM, with Registered Nurse Supervisor #1 presence, Certified Nursing Assistant #1 stated that it was their instinct and reaction to throw the ice cream at Resident #1. The Assistant Director of Nursing also stated they reviewed the surveillance video, and it was confirmed, Certified Nursing Assistant #1 threw a cup with ice cream at Resident #1. The Assistant Director of Nursing stated Certified Nursing Assistant #1 was suspended immediately and terminated as of 01/13/2025.</p> <p>During an in-person interview on 01/22/2025 at 4:18 PM, the Administrator stated the Assistant Director informed them on 01/13/2025 at 7:46 PM that Certified Nursing Assistant #1 threw ice cream on Resident #1 and that it was witnessed by License Practical Nurse #1.</p> <p>The Administrator stated after the camera was reviewed, they agreed with Assistant Director of Nursing there was evidence that abuse occurred. The Administrator stated Certified Nursing Assistant #1 was suspended immediately and terminated as of 01/13/2024.</p> <p>10 NYCRR 415.4(b)(1)(i)</p>		