STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335455	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carmel Richmond Healthcare and Rehab Center	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49081 Based on observation, record review, and interviews conducted during an Abbreviated Survey (NY00353123), the facility failed to provide adequate supervision to a resident to prevent accident. This was evident for one (1) of six (6) residents (Resident #3) sampled. Specifically, Certified Nursing Assistant #9 transferred Resident #3 out of bed to the recliner chair by themself at 8:00 AM [DATE]. After breakfast, Certified Nursing Assistant #9 transferred Resident #3 back to bed by themself at 10:51 AM. While Certified Nursing Assistant #9 was in the process of providing morning care to Resident #3 at 10:51 AM, they observed Resident #3 with a discoloration on the left inner thigh. Registered Nurse #2 and Registered Nurse Supervisor #3 assessed Resident #3 who had a bruise on the left inner thigh. An x-ray result dated [DATE] documented an acute fracture of the left hip. Resident #3 was transferred to hospital on [DATE] at 9:21 PM and returned to the facility on [DATE] at 3:45 PM with principal discharge diagnosis of an acute Left Intertrochanteric Comminuted fracture (a type of bone fracture where the bone is broken into multiple fragments more than two). Resident #3 underwent an Open Reduction Internal Fixation surgery. A Treatment Administration document (Resident Instructions for Certified Nursing Assistants) dated [DATE] had documented instructions for Resident #3 to be transferred by two people using a stand pivot (technique). Certified Nursing Assistant #7, Certified Nursing Assistant #8 and Certified Nursing Assistant #9 did not follow Resident #3's plan of care from [DATE] to [DATE]. The findings include: The facility's policy titled Nurse Aide Assignment and Accountability Record dated ,d+[DATE] documented the purpose of the policy is to ensure that nurse aides are properly assigned, and their activities are documented accurately in the Electronic Health Record (EHR) system to maintain quality care, accountability, and regulatory compliance in the nursing home. The Certified Nurse Aide reviews the Nursing Instructions of those residents he/she is assigned, to ensure that the resident plan of care is followed. The facility's policy titled Safeguarding the Resident was revised on ,d+[DATE]. The policy documented that all residents will be provided with care in a safe manner and according to the resident plan of care. The staff is educated regarding safety issues and how to avoid injury to the residents. Resident #3 admitted to the facility with diagnoses including Dementia and Anxiety Disorder. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Minimum Data Set, a resident assessment tool, dated [DATE] documented Resident #3 had severe cognitive impairment. Resident #3 required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provide less than half the effort) for transfer. An Activities of Daily Living Care Plan dated [DATE] documented Resident #3 was total dependent for two persons using a stand pivot for chair-to-bed and bed-to-chair transfer. The Treatment Administration (Resident Instructions for Certified Nursing Assistant) dated [DATE] documented that Resident #3 required two persons for transfer using a stand pivot. The Accident/Incident Report dated [DATE] at 10:51 AM and Investigative Summary dated [DATE] documented Resident #3 was observed with increased restlessness in the dining room by yelling and swinging their arms and legs over their recliner chair. Resident #3 stated, my clothes pain me. Resident #3 was transferred back to bed by Certified Nursing Assistant #9 who reported Resident #3 had a left inner thigh discoloration that was observed during care. Resident #3 was assessed by Registered Nurse #2 and Registered Nurse Supervisor #3 to have a purplish discoloration on left inner thigh. Medical Doctor #2 and Resident #3's family member was notified. Medical Doctor #2 ordered an x-ray of left the hip and femur. The x-ray result dated [DATE] revealed an acute intertrochanteric fracture of left hip. Osteopenia and degenerative changes noted. The investigation also documented that they reviewed the video footage from [DATE] to [DATE] and it showed Certified three Certified Nursing Assistants (#7, #8, and #9) transferred Resident #3 without assistance. The investigation concluded that abuse and neglect did not occur as the Certified Nursing Assistants had no malicious intent to hurt Resident #3. The Certified Nursing Assistants were also suspended pending the investigation outcome. A nursing note by Registered Nurse Supervisor #3 dated [DATE] at 11:39 AM, documented Resident #3 was observed with increased yelling, restlessness and agitation. Resident #3 was swinging their arms and legs over the recliner and was shifting their body. Registered Nurse Supervisor #3 was called and examined Resident #3 who was observed with a purpura discoloration to their left inner thigh. The resident skin was intact and positive range of motion to all extremities was at baseline. Resident #3 was asked if they were in pain and stated, my clothes pain me. The clothing was changed, and Resident #3 had no further complaints of pain. Registered Nurse Supervisor #3 reviewed the resident chart, and the resident was on Aspirin and recently gradual dose reduction of Depakote was done on [DATE]. Medical Doctor #2 ordered an x-ray of left hip and femur. A Radiology Report dated [DATE] at 8:19 PM, documented an Acute Intertrochanteric Fracture of Left Hip. Fracture was not present on previous study of [DATE]. Osteopenia degenerative changes noted. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:26 PM, Certified Nursing Assistant #9 stated on [DATE] they transferred Resident #3 out of bed by themself and brought the resident into the dining at 8:00 AM for breakfast. Certified Nursing Assistant #9 stated they did not experience any difficulty when they transferred Resident #3 out of bed, and they did not observe any discoloration on Resident #3's skin. Certified Nursing Assistant #9 stated that they observed Resident #3 with the discoloration between their left inner thigh after they transferred Resident #3 back to bed on [DATE] at 10:51 AM and while they were providing care to the resident. Certified Nursing Assistant #9 stated they reported their observation to Registered Nurse #2. Certified Nursing Assistant #9 stated Resident #3 had behaviors of being loud, restless, agitated, and swinging their arms and legs when sitting in their recliner. Certified Nursing Assistant #9 stated that they violated Resident #3's plan of care which called for two persons for transfer. Certified Nursing Assistant #9 stated it is their responsibility to read Resident #3's instructions prior to providing care. During a telephone interview on [DATE] at 1:00 PM, Certified Nursing Assistant #8 stated that they floated to Resident #3's unit on [DATE] on the night shift (10:00 PM-6:00 AM). Certified Nursing Assistant #8 stated Resident #3 was not a regular on their assignment and they received training to read the instructions prior providing care. Certified Nursing Assistant #8 stated they transferred Resident #3 back to bed by themself without calling another staff member for assistance. Certified Nursing Assistant #8 stated they recalled checking the computer and it states that Resident #3 requires one person assistance. Certified Nursing Assistant #8 stated after the incident they (facility) updated the plan of care for two persons assist for transfer. Certified Nursing Assistant #8 stated they did not have any issues when they transferred Resident #3 on [DATE] and there was no discoloration to the resident's inner thigh. Certified Nursing Assistant #8 stated they received report every night from the charge nurse prior starting to their work. During an interview on [DATE] at 1:21 PM, Certified Nursing Assistant #7 stated they were new on the job and their regular shift was night shift (10:00 PM-6:00 AM), but they were asked to stay over on [DATE] and was assigned to the day shit from 6:00 AM to 2:00 PM. Certified Nursing Assistant #7 stated they gave Resident #3 a shower on [DATE] and transferred the resident by themself. Certified Nursing Assistant #7 stated it was the first time being assigned to Resident #3 and that the resident did not fall or hurt themself during the transfer. Certified Nursing Assistant #7 stated they received training /orientation on providing care, documentation and using the buddy system prior to starting their work assignments. Certified Nursing Assistant #7 stated they did not know what a Kardex (Instructions to Certified Nursing Assistant) means and did not know where to find the Kardex or Resident Instructions in the computer during their orientation. Certified Nursing Assistant #7 stated they do not recall receiving hands-on training in reading the instructions in the computer. Certified Nursing Assistant #7 stated they did not observe any of the staff on the unit transferring Resident #3 with two persons assist. Certified Nursing Assistant #7 stated they were suspended during the investigation, and they did not return to the facility. A follow up telephone interview was done on [DATE] at 3:30 PM. Certified Nursing Assistant #7 stated they buddied with other staff during their orientation and assist them with their residents' assignments. Certified Nursing Assistant #7 stated when they were in buddy system orientation, they were shown where in the computer to document but was not shown where to locate the residents' instructions. Certified Nursing Assistant #7 stated they did not notify the nurse or supervisor of not knowing where to locate and review the residents' instructions. Certified Nursing Assistant #7 stated they were not aware of the Kardex and the nursing instructions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 2:10 PM, Registered Nurse #2 stated Certified Nursing Assistant #9 notified them of skin changes on left inner thigh. Registered Nurse #2 stated they assessed Resident #3 and observed a purplish bluish discoloration on the left inner thigh. Registered Nurse #2 stated Resident #3's skin was intact, there were no swelling or external rotation of the thigh. Registered Nurse #2 stated they notified Registered Nurse Supervisor #3. Registered Nurse #2 stated they did not observe when Certified Nursing Assistant #9 transferred Resident #3 by themself. Registered Nurse #2 stated they are responsible for monitoring the staff on the unit to ensure the plan of care is being followed. Registered Nurse #2 stated they gave report to the staff prior start of the shift and to report anything unusual. Registered Nurse #2 stated Resident #3 did not sustain any trauma or fall during their shift. During an interview on [DATE] at 1:48 PM, Registered Nurse Supervisor #3 stated Registered Nurse #2 notified them of Resident #3's discoloration on [DATE] at approximately 10:50 AM. Registered Nurse Supervisor #3 stated they assessed the Resident #3 and observed a purpura (a purple spot due to small blood vessels leaking blood into the skin) on the resident's left inner thigh. Registered Nurse Supervisor #3 stated Resident #3 was confused and was unable to state what happened. Registered Nurse Supervisor #3 stated they asked if Resident #3 had any pain and the resident stated, my clothes pain me. Registered Nurse Supervisor #3 stated that Certified Nursing Assistant #9 changed Resident #3's clothes and Resident #3 did not make any further complaints. Registered Nurse Supervisor #3 stated prior to the incident, Resident #3 was observed with increased restlessness, yelling, swinging their arms and legs over the recliner chair. Registered Nurse Supervisor #3 stated they notified the Medical Doctor of the discoloration, and they examined Resident #3 and ordered an x-ray of the left hip and femur. During an interview on [DATE] at 3:50 PM, the Assistant Director of Nursing stated they were notified of the discoloration on [DATE] (does not remember the time) by Registered Nurse Supervisor #3. The Assistant Director of Nursing stated it was an injury of unknown origin because they do not know how the fracture happened. The Assistant Director of Nursing stated they reviewed the video footage and looked back three days discovering three Certified Nursing Assistants (#7, #8, and #9) transferred Resident #3 by themselves. They did not follow the resident plan of care. The Assistant Director of Nursing stated that they suspended the three staff members pending investigation outcome. The Assistant Director of Nursing stated the Law Enforcement was notified and responded. During a telephone interview on [DATE] at 12:49 PM, Medical Doctor #2 stated they were not familiar with Resident #3, however, they examined Resident #3 who had a purplish discoloration on their left inner thigh. Medical Doctor #2 stated they ordered an x-ray of the left hip and femur. Medical Doctor #2 stated they received report about the result of the x-ray and ordered Resident #3 to be transferred to the hospital. Medical Doctor #2 stated they did not receive any reports of a fall or trauma and that they do not know how Resident #3 sustained the fracture. 10NYCRR 415.12(h)(2)