| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335459 | A. Building<br>B. Wing | 08/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Westchester Center for Rehabilitation & Nursing | 10 Claremont Ave<br>Mount Vernon, NY 10550 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>49372<br><br>Based on record review and interviews conducted during an abbreviated survey (NY00311197) the facility did not ensure the resident's right to be free from abuse for 1 (Resident #1) of 3 residents reviewed for physical abuse. Specifically, Resident #1 reported they were shoved by Certified Nurse Assistant #1 that on 2/20/2023 at 12am. Resident #1 tried to show the Certified Nurse Aide how to operate the overhead light and Certified Nurse Assistant #1 shoved Resident #1 with their shoulder onto the bed in the resident's room.<br><br>Finding include:<br><br>A review of the abuse policy-prevention and management dated 3/2016 and last revised 9/8/22 documented the facility prohibits the mistreatment and abuse of residents by anyone including staff. The Facility has designed and implemented processes which strive to ensure the prevention and reporting of suspected or alleged resident/patient abuse. The Facility must provide a safe resident environment and protect residents from abuse.<br><br>Resident #1 was admitted to the facility with diagnoses including Asthma, Syncope and collapse and lack of coordination.<br><br>A Quarterly Minimum Data Set (an assessment tool) dated 2/4/24 documented the resident had a Brief Interview of Mental status score of 15, indicating cognitively intact. The resident had visual impairment and wore glasses, but hearing and speech were intact. Resident #1 was independent in activities of daily living and was continent of bowel and bladder .<br><br>Review of the Facility Incident Report dated 2/20/23 documented Resident #1 reported that Certified Nurse Assistant entered their room and tuned on the light and light shone in their face. Resident #1 got up and showed the aide the overbed light and the aide shoved her. Assessment was completed. No injuries or bruising noted or complaints of pain.<br><br>Review of employee record dated 2/2023 documented Certified Nurse Assistant #1 was terminated because Resident #1 reported they shoved them during care.<br><br>(continued on next page) |

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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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/4/24 at 11:20 AM, Resident#1 stated there have been ongoing issues on and off with staff. There have been some unruly aides at times. Resident #1 stated the incident was starting to come back to them and they remember, the shoving with an elbow like don't tell me what to do. Stated this occurred in their room, and that they walk with a walker and could have been thrown over. Stated normally they report uncontrollable incidents, like words being exchanged or if staff state things like it is not my job or I don't have to turn the light off, they will report it to the Director of Nursing. Stated the staff is generally good, but the night shift can be a problem. There are new faces and transfers that cover the floor, that usually cause the problems. Stated again, for them to report anything it had to be something that provoked them. It must have been a bad shove.<br><br>During an interview on 4/4/24 at 1:20 PM the Director of Nursing stated they were informed that Certified Nurse Aide #1 pushed Resident #1 during the night shift and the resident reported it the next morning. Stated the facility immediately started an investigation and assessed the resident for any injuries.<br><br>During an interview on 4/4/24 at 3:55 PM Staff #2 (Registered Nurse supervisor 3-11 PM shift) stated they remember Resident #1 stated Certified Nurse Aide #1 shoved them. Stated Resident #1 is alert, and they demonstrated exactly what had occurred.<br><br>During a follow up interview on 4/15/24 at 9:20 AM the Assistant Director of Nursing stated there was no evidence to substantiate the abuse. There was no video of the incident, it happened in the resident's room. Stated in their conclusion they documented the abuse was unsubstantiated.<br><br>10NYRCC 415.4(b)(1)(i) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372<br><br>Based on record review and interviews during an abbreviated survey (NY00311197, NY00332234) the facility did not ensure an allegation of abuse was thoroughly investigated and the results of the investigation reported to the New York State Department of Health, in accordance with State law within 5 working days of the incident for 2 (Resident #1, #4) of 6 residents reviewed for abuse. Specifically, Resident #1 reported that they were shoved by a Certified Nurse Aide on 2/20/23 at approximately 12 AM in their room, when trying to show them how to work the overbed lighting of their roommate. The facility did not provide documentation of the completed investigation and no report was submitted to the New York State Department of Health. 2) Resident #4 reported to Certified Nurse Assistant #5 that on 1/25/2024, Licensed Practical Nurse #2 pinched them on the left lower leg. The facility did not provide any statements obtained from Resident #2's roomate and staff and Licensed Practical Nurse #2 contiued to to provode direct care to Residnet #2 until 8/2/2024.<br><br>Finding include:<br><br>A review of the Abuse Policy-Prevention and Management dated 3/2016 and last revised 9/8/22 documented all allegations/occurrences of all types of staff-resident abuse must be reported to the State Survey Agency.<br><br>Resident #1 had diagnoses including asthma, syncope and collapse and other lack of coordination.<br><br>Resident #1's Quarterly Minimum Data Set (an assessment tool) dated 2/4/24 documented the resident had a Brief Interview of Mental Score of 15/15 indicating intact cognition. The resident had visual impairment and wore glasses, but hearing and speech was intact. Resident #1 was independent in activities of daily living and was continent of bowel and bladder.<br><br>Review of the incident/accident report dated 2/20/23 revealed it was not completed. Further review revealed there was no documentation of an investigation conclusion, or 5-day report enclosed. No documented evidence of the incident being report to Department of Health was provided.<br><br>During an interview on 4/4/24 at 1:20 PM, the Director of Nursing stated the facility immediately initiated an investigation and assessed Resident #1 for any injuries. The Director of Nursing stated the nursing supervisor on the unit that the incident was reported to completes the Accident/Incident report. The Director of Nursing stated the Assistant Director of Nursing reviewed the report, and they decided it was a reportable incident and reported it to the Department of Health and the Administrator. The Director of Nursing stated they were waiting on the Department of Health to request the 5-day report before submitting. The Director of Nursing stated the Department of Health tells them if they need to send the report depending on if the investigation is concluded and they have done all that is required to do.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/4/24 at 2:40 PM, the Assistant Director of Nursing stated they recall the allegation by Resident #1 of a Certified Nurse Aide shoving them. The Assistant Director of Nursing stated a reportable report was completed for the allegation of physical abuse. The Assistant Director of Nursing stated they were informed about the allegation by the Registered Nurse Supervisor (Staff #2) and they immediately removed the Certified Nurse Aide #1 from the unit to ensure Resident #1 was safe. The Certified Nurse Aide #1 was also removed from the schedule pending investigation. A full body assessment was completed and staff and other residents on the unit were interviewed. A background check was also conducted on the Certified Nurse Aide #1 to determine if they had any prior incidents of resident abuse and there were no findings of any prior allegations.The Assistant Director of Nursing stated all staff on 2 shifts received an in-service on abuse, neglect, and mistreatment.<br><br>The Assistant Director of Nursing stated they completed the reportable incident report, they have 2 hours to report the incident to the State. The Assistant Director of Nursing stated they started the investigation immediately and collected any statement from the staff and the resident. The Assistant Director of Nursing stated they also assessed Resident #1 for psychological harm by assessing for withdrawal, grimacing, crying or fright no there was no psychological harm noted. The Assistant Director of Nursing stated they then ensured that Social Work followed up with Resident #1 and a possible referral for psychiatry evaluation. The Assistant Director of Nursing stated the incident would be documented in the abuse care plan section they would update the abuse care plan. The assistant director of Nursing stated they stated in the 5 day follow up, they would state if there were any additional findings and document anything that would impair the resident, in the conclusion. The Assistant Director of Nursing stated they would document anything that would impair the resident in the conclusion as they must prove that the resident is free from abuse. The Assistant Director of Nursing stated they could not recall who the staff member was.<br><br>During an interview on 4/4/24 at 3:55 PM, Staff #2 (Registered Nurse Supervisor 3-11 PM shift) stated they remember Resident #1 stated the Certified Nurse Aide #1 shoved them. Registered Nurse Supervisor stated they investigated the incident by asking Resident #1 and the Certified Nurse Aide #1 what happened. Registered Nurse Supervisor stated they also asked the other Certified Nurse Aides on the unit if they knew what happened, but no one else saw the incident. Registered Nurse Supervisor stated they do not remember if they completed the incident report. Registered Nurse Supervisor stated they were working the day shift the resident reported the incident. Registered Nurse Supervisor stated the person who receives the report of the allegation is supposed to initiate the Accident/Incident report. Registered Nurse Supervisor stated this type of incident would be abuse, so it will be reported to the state. Registered Nurse Supervisor stated the Assistant Director of Nursing is the one that would report to the state. Registered Nurse Supervisor stated Certified Nurse Aide #1 was an employee of the facility and worked part time or per diem. Registered Nurse Supervisor stated the Certified Nurse Aide was taken off the schedule. Registered Nurse Supervisor stated Resident #1 is alert, and a body assessment was completed. Resident #1 demonstrated exactly what had occurred. Staff #2 stated they also interviewed Resident #1 and reassured them they would address the issue. Registered Nurse Supervisor stated the documentation in the chart would be a note stating assessment was done and no abnormalities were noted.<br><br>During a follow up interview on 4/15/24 at 9:20 AM, the Assistant Director of Nursing stated there was no evidence to substantiate the abuse. There was no video of the incident, it happened in the resident's room. The Assistant Director of Nursing stated in their conclusion they documented the abuse was unsubstantiated.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a follow up interview on 4/15/24 at 12:20 PM, the Director of Nursing stated they would usually ask the residents if anybody else had a concern with the Certified Nurse Aide cares. The Director of Nursing stated they were unsure if a full body assessment was completed for the other residents the certified nurse aide cared for or if they were reported to the State. The Director of Nursing stated being Staff #5 was agency staff, the facility would report the incident to the agency, and state that they were removed from the schedule and why, then the agency would be the ones to report them to the state because they are not facility staff. The Director of Nursing stated they would call or email the agency contact person and inform them of the incident.<br><br>2.<br><br>Resident #4 was admitted to the facility with diagnosis including but not limited to Alzheimer's, Dementia and Delusional disorder.<br><br>A Quarterly Minimum Data Set, dated dated dated [DATE] documented the resident had a Brief Interview for Mental Status score of 12 associated with moderate cognitive impairment.Resident #4 required set up with meals, maximun assistance for toiletting and moderate assistance for bed mobility and transfers. No behaviors documented.<br><br>Review of the Resident #4's statement dated 1/25/2024 written by the Assistant Director of Nursing documented Licensed Practical Nurse #2 saw their foot hanging off the bed. Licensed Practical Nurse #2 put their foot back into the bed. The statement documented Licensed Practical Nurse #2 kept on pinching them and the area was sore, pointing to their left leg. Resident #4 complained of soreness at the site and stated Licensed Practical Nurse #2 did it.<br><br>During an interview on 8/2/2024 at 4:00 PM, Licensed Practical Nurse #2 stated they have been working in the facility for almost [AGE] years. Licensed Practical Nurse #2 stated they remember Resident #2 stated that they pinched them. Licensed Practical Nurse #2 stated they were assigned to Resident #4, on 1/26/2024 on the 3 PM- 11 PM shift, and they do not remember the resident exhibiting any behaviors that night. Licensed Practical Nurse #2 stated they have worked with Resident #4 since the day of the incident except when they were suspended. They have been on the same unit with Resident #4 and work on the same side of the floor, since the incident occurred on 1/26/2024.<br><br>During a telephone interview on 8/5/2024 at 2:20 PM the Assistant Director of Nursing (former) stated Resident #4 told them they were pinched by a nurse, but the resident could not determine if it happened onn the day or the night before and the story kept changing. The Assistant Director of Nursing stated Licensed Practical Nurse #2 was suspended and returned to work the week after. Stated when Licensed Practical Nurse #2 returned, they worked on the same unit with Resident #4. The Assistant Director of Nursing stated they could not prove that Licensed Practical Nurse #2 pinched Resident #4. Stated Licensed Practical Nurse #2 was suspended for not reporting the incident. The Assistant Director of Nursing stated they did not interview or assess any other residents Licensed Practical Nurse #2 cared for on 1/25/2024, at the time of the incident. Stated the protocol in the facility is to interview the resident involved or the staff involved that cared for or interacted with the resident during the alleged time period.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a telephone interview on 8/5/2024 at 3:30 PM the Director of Nursing stated they have been in the facility for 2 months.The Director of Nursing stated for an abuse allegation they would remove staff right away from the schedule, and if the allegation was unsubstantiated, they would place the staff on another unit when they returned to work. The Director of Nursing stated interviews would be conducted with the resident's roommate, if they are able to be interviewed and any alert residents on the staff's assignment would be interviewed. The Director of Nursing stated Licensed Practical Nurse #2 was removed from the Resident #4's unit on Friday 8/2/2024 and reassigned during the onsite survey.<br><br>10NYRCC 415.4 |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>49372<br><br>Based on record review and interviews conducted during an abbreviated survey (NY00311197), the facility did not ensure the comprehensive care plan was reviewed and revised for 1 (Resident #1) out of 3 residents reviewed for care planning. Specifically, Resident #1's abuse care plan was not updated to reflect an allegation of abuse on 2/20/2023.<br><br>Finding include:<br><br>A review of the abuse policy-prevention and management dated 3/2016 and last revised 9/8/2022 documented the facility prohibits the mistreatment and abuse of residents by anyone including staff. The Facility has designed and implemented processes which strive to ensure the prevention and reporting of suspected or alleged resident/patient abuse. The Facility must provide a safe resident environment and protect residents from abuse.<br><br>Resident #1 had diagnoses including asthma, syncope and collapse and other lack of coordination.<br><br>A Quarterly Minimum Data Set (an assessment tool) dated 2/4/2024 documented the resident had a Brief Interview of Mental Score (BIMS) Score of 15/15, indicating cognitively intact. The resident had visual impairment and wore glasses, but hearing and speech were intact. Resident #1 was independent in activities of daily living and was continent of bladder and bowel.<br><br>An abuse and neglect care plan dated 6/10/2022 documented the resident is at risk for abuse/neglect related to periods of anger and a diagnosis of anxiety and documented an intervention to encourage ventilation of feelings.<br><br>Review of the abuse and neglect care plan documented that on 2/10/2023 and 5/12/2023, the resident remained free from abuse. There was no documentation of the incident that occurred on 2/20/2023.<br><br>A review of the psychosocial care plan dated 6/10/2022 had no documented updates since initiated. Furthermore, there was no update on the care plan regarding the alleged abuse on 2/20/2023.<br><br>During an interview on 4/4/2024 at 1:05 PM, the Director of Social Services stated the incident should have been documented on an abuse or psychosocial care plan by the previous Social Worker who no longer works for the facility.<br><br>During an interview on 4/4/2024 at 1:20 PM, the Director of Nursing stated the care plans should have been updated and as needed.<br><br>During an interview on 4/4/2024 at 2:40 PM, the Assistant Director of Nursing stated the incident should be documented on the abuse care plan section. The Assistant Director of Nursing stated they would update the abuse care plan after the initial submission to the Department of Health.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/4/2024 at 3:55 PM, Staff #2 (Registered Nurse supervisor 3-11 PM shift), stated the person who receive the initial report of the allegation is supposed to initiate the Accident/Incident report and they are also responsible to initiate or update the care plan.<br><br>10 NYCRR 415.11 (c)(2)(ii) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372<br><br>Based on record review and interview during an abbreviated survey (NY00303362) the facility did not ensure that each resident received adequate supervision and assistive devices to prevent accidents for 1 (Resident #2) of 3 residents reviewed for accident. Specifically, Resident #1 upon admission was scored as a mild fall risk and there was no documented evidence of any safety measures or assistive devices in place for use to prevent an accident. Resident #1 subsequently had a fall on 10/12/2022 and sustained a left wrist fracture and a laceration to the left eye.<br><br>Finding include:<br><br>A review of the facility's undated fall prevention/bed alarm/chair alarm/risk management policy under philosophy documented residents will be assessed on admission, readmission or whenever a change in condition occurs, for risk factors to prevent accident/incidents. Subsequently, an individualized plan of care will be formulated in conjunction with the comprehensive care plan that identifies risk factors and intervention of accident/incidents. An accident is defined as an unexpected, unintended event that cause a resident bodily injury. Examples of accidents may include, but are not limited to the following: fractures, lacerations requiring closure, burns (2nd, 3rd degree), hematoma, ecchymosis greater than 4 cm, head injuries and injuries of unknown origin.<br><br>Resident #2 had diagnoses including but not limited to Dementia, unsteadiness on feet and other lack of coordination.<br><br>The Admission Minimum Data Set, dated dated dated [DATE] documented Resident #2 had a Brief Interview for Mental Status (BIMS, used to determine attention, orientation, and ability to recall information) score of 02/15, associated with severe cognition impairment Resident #2 exhibited rejection of care behavior and required extensive assistance for bed mobility, transfers, and toileting. Resident #2 had impairment to both upper and lower extremities and was unstable with ambulation needing staff assistance.<br><br>Review of a Fall Risk assessment dated [DATE] documented Resident #2 was alert and oriented or comatose, had a balance problem while standing and walking. The resident had poor muscle coordination and a change in pattern while walking. Resident #2 was scored at a 6 indicating a medium risk for falls.<br><br>Further review of the Fall Risk assessment revealed Resident #2 was not scored for their impaired vision.<br><br>A Fall Care Plan last reviewed 07/12/2022 reflected Resident #2 was a fall risk due to been unsteady on their feet, had confusion and disorientation. Documented interventions included to ensure the resident was wearing proper footwear.<br><br>There was no documented evidence of specific safety measures in place or assistive devices in use to prevent Resident #2 from accidents or falls.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Certified Nurse Aide #3's statement in the accident incident report dated 10/12/2022 documented that they last saw Resident #2 in bed asleep when they checked on them at 6:20 AM. The Certified Nurse Aide documented that the resident had a bed alarm in place and it was on, and the resident had socks on their feet. Stated the side rails were not up and there was no floor mat in place.<br><br>During an interview on 4/5/2024 at 12:20 PM the Director of Nursing stated they always anticipate every resident is a fall risk, being in a new environment. The Director of Nursing stated after admission, residents are assessed, and a fall care plan is initiated. The Director of Nursing stated stated a resident that is considered to be a high risk on assessment at admission is one who is not ambulatory. Stated these residents will have the following interventions implemented floor mats, bed in the lowest position and 15 min checks first 48 hours. The Director of Nursing stated If a resident required extensive assistance, then they are considered non-ambulatory.<br><br>Attempts to reach Certified Nursing Assistant #3 by phone was unsuccessful.<br><br>10 NYCRR 415.12(h)(1) |