STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335459	A. Building B. Wing	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westchester Center for Rehabilitation & Nursing	10 Claremont Ave 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 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** 44266 Based on observations, interviews and record review conducted during an abbreviated survey (NY00341327, NY00358946, NY00357076), the facility did not provide adequate supervision/monitoring to prevent accidents for 2 of 6 residents (Resident #3 & #10) reviewed. Specifically, (1) Resident #3 who had a history of suicidal attempts and cut their left wrist sustaining a laceration that was unwitnessed by staff on 05/04/2024 was placed on 1:1 monitoring following the incident had no documented 1:1 monitoring. Resident #3 was found by Certified Nurse Aide with blood on his gown and on the floor on 5/5/2024 and was transferred to the hospital for further evaluation. The investigative summary concluded Resident #3 used a pointed pencil to harm self; (2) Resident #10 who had severe cognition impairment and had history of multiple falls sustained a head injury from an unwitnessed fall on 10/09/2024 and was transferred to the hospital for further evaluation Resident #10 had falls with no injury on 02/18/2024, 04/09/2024, 04/22/2024, 06/05/2024, 08/25/2024, and 10/07/2024 but there was no documented evidence of appropriate care plan interventions to prevent further falls and had no Physical Therapy Evaluation and Occupational Therapy Evaluation after each fall. Findings include: The Facility Policy titled Incident and investigation of accidents hazards, supervision and assistive devices last revised on 7/31/2024 documented an avoidable accident means an accident occurred because the facility failed to identify environmental hazards and assess individual residents risk of an accident, including the need for supervision and /or assistive devices; to analyze the hazards/risks and eliminate them or if not possible, identify and implement measures to reduce the hazard risks, implements measures including adequate supervision and assistive devices, consistent with a resident's needs to reduce accidents and monitor for the effectiveness of the interventions and modify care plan as necessary. Resident #3 had diagnoses including Major Depressive Disorder, Colostomy Complication, Essential Hypertension and Morbid Obesity. The Quarterly Minimum Data Set (MDS, an assessment tool) dated 6/13/2024 documented the resident had a Brief Interview for Mental Status (BIMS, used to determine attention, orientation, and ability to recall information) score of 15/15, associated with intact cognition (00-7 severe impairment, 08-12 moderate impairment and 13-15 cognitively intact). (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive care plan initiated 02/23/2024 documented that Resident #3 was at risk for harm and had a goal to maintain clutter free environment and staff will continue 30-minute rounding to ensure safety. Interventions included to conduct environmental rounds every shift. Facility Incident/Accident Investigation dated 05/04/2024 documented Resident #3 as alert and oriented with a Brief Interview for Mental Status of 15. Resident #3 reported they were trying to open a canned drink and accidentally cut themselves on the left wrist. Resident #3 refused hospital transfer despite the presence of paramedics. Wound dressed, physician and family notified. Resident #3 was encouraged to call for assistance. Nursing Progress Note dated 5/4/2024 documented that around 4:20 PM, Certified Nurse Aide reported they noted a skin laceration on Resident #3's left wrist area. The writer attended immediately to observe a resident with a cut on the left wrist. According to resident, they stated they were trying to open a can and accidentally cut their left wrist sustaining a laceration on the left wrist. Physician ordered transfer to the hospital and when the ambulance arrived, Resident #3 refused to go to hospital. Physician notified of Resident #3 refusal to go to hospital. Physician ordered Augmentin for Left Wrist Laceration and Left Wrist Laceration area cleaned with normal saline and bacitracin applied with dry dressing. Resident #3 is on 30-minute monitoring and staff continue to watch the resident closely, call bell within reach. Resident #3 advised to call staff for anything they needed. Facility Incident/Accident Investigation dated 5/5/2024 documented Resident #3 was observed using a pencil to harm themselves. Resident was sent out immediately to the hospital. Review of Resident #3 Electronic Monitoring Record (EMR) revealed no 30-minute monitoring for 5/4/2024 through 5/5/2024. During an interview conducted on 1/8/24 at 11:26 AM, Certified Nurse Aide #1 stated they were assigned to Resident #3 on 5/5/2024 and was working with another resident when the nurse informed them that Resident #3 had cut themself. Certified Nurse Aide #1 stated they left Resident #1 with the nursing staff to care for the other resident. Certified Nurse Aide #1 denied knowing any interventions in place for Resident #3 regarding close monitoring or that the resident had suicidal history. During an interview conducted on 1/8/2025 at 11:47 AM, Certified Nurse Aide #2 stated when they came into work on 5/5/2024 they were informed that there had been an incident with Resident #3 cutting themself the day before. Certified Nurse Aide #2 stated it was reported that no one knew what they had cut themself with. Certified Nurse Aide #2 stated they suggested they put Resident #3 on 30-minute monitoring, and they also went and scanned the room for safety. Certified Nurse Aide #2 stated there was a pair of scissors present and they notified the supervisor. Certified Nurse Aide #2 stated the supervisor removed the scissors and Resident #3 was upset stating they needed the scissors for their colostomy care. Certified Nurse Aide #2 stated they told them they would have to remove the scissors or call the Director of Nursing and Resident #3 let them remove the scissors. Certified Nurse Aide #2 stated later in the day they heard the nurse scream and ran to the resident room. Certified Nurse Aide #2 stated they grabbed a clean blanket and held it on Resident #3's wound. Certified Nurse Aide #2 stated Resident #3 was fighting and being resistant with the care and continued to state that they wanted to die. Certified Nurse Aide #2 stated 911 was called and the resident was sent out to the hospital. Certified Nurse Aide #2 denied knowing of any interventions in place for Resident #3 regarding monitoring or suicidal history prior to 5/5/2024. (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 1/8/2025 at 12:58 PM, the Nursing Supervisor#1 stated they were notified by staff that a Resident #3 was bleeding on 5/4/2024, and they went to assess. Nursing Supervisor #1 stated Resident #3 reported they were trying to open a can drink and sustained an injury but Resident #3 was bleeding from the wrist and their injury was not consistent with the story they were reporting. Nursing Supervisor #1 stated after the assessment they looked to see if there was anything in the room that the resident could use to harm themself but did not find anything. Nursing Supervisor #1 stated they called 911 and Resident #3 refused to go to the hospital. Nursing Supervisor #1 stated the Director of Nursing was notified and they were instructed to place Resident #3 on 1 to 1 monitoring. Nursing Supervisor #1 stated they placed Resident #3 on every 15-minute monitoring instead. Nursing Supervisor #1 stated such monitoring is usually documented on a form. Nursing Supervisor #1 stated they were not aware of Resident #3's suicidal history until after the incident when they read through their chart. During an interview on 1/8/2025 at 12:51 PM, Certified Nurse Aide #3 stated they were handing out trays on 5/4/2024 and when they opened the door to Resident #3's room they saw blood on the floor. Certified Nurse Aide #3 stated they followed the trail and saw blood all over, so they asked Resident #3 what had happened. Certified Nurse Aide #3 stated Resident #3 stated nothing happened and that they were trying to open a can and sustained an injury. Certified Nurse Aide #3 stated they notified the nurse. Certified Nurse Aide #3 stated they questioned Resident #3 asking them if they were trying to open a can, how did they cut themself on the wrist. The injury was not consistent with the story Resident #3 was reporting. The facility wanted to send the resident out to the hospital, but the resident refused. Prior to the incident, the only complaint the resident had was about the food, otherwise the Resident #3 was fine. Certified Nurse Aide #3 denied any knowledge of Resident #3 having behaviors or been placed on close monitoring. During an interview on 1/8/2025 at 2:45 PM, the Director of Nursing stated they were unable to locate every 30 Minute Monitoring for Resident #3 on 5/4/2024 & Every Shift Monitoring from 2/22/2025 to 5/4/2025. During an interview conducted on 1/8/2025 at 3:10 PM, the Director of Nursing stated they were not employed at the time of Resident #3's admission, but they expect monitoring to be done and documented when put in place. During an interview conducted on 1/8/2025 at 3:29 PM, the Administrator stated their expectation would be for monitoring to be done when put in place. However, they did not expect for monitoring to be documented. The Administrator stated they would expect for monitoring to be more of keeping a close eye on the resident. Resident #10 had diagnoses including but not limited to lack of coordination, dementia, and transient cerebral ischemic attacks. Resident #10 was residing in the facility's locked dementia unit. A Minimum Data Set, dated dated dated [DATE] documented a Brief Interview for Mental Status assessment score of 4/15 associated with severe cognition impairment. Resident #10 required supervision while walking with a walker and supervision with meal set-up, bathing, dressing, and bed mobility. Resident #10 had a wander/elopement alarm on. Resident #10 had one fall without an injury. The Discharge MDS dated [DATE] documented that Resident #10 had 3 falls- one with an injury and 2 falls without an injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Accident/Incident Report dated 10/9/2024 revealed that on 10/9/2024 at around 8:00 AM Resident #10 was found on the floor outside the bathroom in their room with bleeding from the head noted. When the resident was assessed, visible bleeding from the head was noted, rolling walker was seen near the bathroom door. 911 was activated. Next of kin was notified of incident and resident's status. Emergency Medical Service arrived immediately, and the resident was transferred out to the hospital. Review of Fall Risk Assessments revealed that Resident #10 was identified as high risk for fall since 1/22/2024 but had no comprehensive care plan in place to prevent falls. Review of the Physical Therapy Evaluation dated 2/12/2024, revealed that Resident #10's balance during transitions and walking was scored as follows: moving from seated to standing position, walking with assistive device, turning around while walking, moving on and off toilet and surface to surface transfer: 2 = not steady, only able to stabilize with human assistance. Review of the Occupational Therapy Evaluation dated 2/12/2024, revealed that Resident #10 scored a total of 24 out of 105, in the Barthel Index Scoring Form (an assessment tool, used to measure the ability to perform basic activities of daily living like bathing, dressing, eating, toileting, chair-to-bed transfers, walking and grooming). A score of 21-60 means severe dependency. Record review facility nursing progress notes revealed Resident #10 had falls with no injury on 02/18/2024, 04/09/2024, 04/22/2024, 06/05/2024, 08/25/2024, and 10/07/2024 but there was no documented evidence of appropriate care plan interventions such as consistent monitoring to prevent further falls Record review revealed that the resident had no Physical Therapy Evaluation and Occupational Therapy Evaluation after fall incidents on 02/18/2024, 04/09/2024, 04/22/2024, 06/05/2024, 08/25/2024, and 10/07/2024. Physical and Occupational therapy evaluations conducted on 8/27/2024 and 10/7/2024 but the functional status evaluation was not documented in the evaluation. During an interview on 1/10/2025, at 3:02pm, with the Director of Nursing (DON), stated, their expectations when a fall occurs are as follows: the accident investigation form needs to be filled out immediately, the physician and family need to notified, the pain, skin and fall assessments need to be done, to obtain physician orders for physical and occupational therapy and for x-rays, we discuss the fall in risk management meetings and the care plan must be updated. To prevent falls, we may ask for one or more of the following physician orders such as room change (near the nurses' station), low bed or baseline pain management. Upon a resident's admission, we check for history of falls or repeated falls. We continue to have care plan meetings and interdisciplinary team meetings with all department directors and with our physician in morning meetings. During an interview was on 1/13/2025, at 3:11pm, with Resident #10's representative who is also the healthcare proxy they stated, every time I attended a care plan meeting with the Director of Social Services, they were told they would move Resident #10 to the room closest to the nurses' station. This was never done. (continued on next page)

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