

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335462	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/09/2025
NAME OF PROVIDER OR SUPPLIER The Plaza Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 100 West Kingsbridge Road Bronx, NY 10468	

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during an Abbreviated Survey (2622908), the facility did not ensure that all alleged violations involving abuse, neglect, including injuries of unknown source were reported immediately, but not later than 2 hours after the allegation was made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the New York State Department of Health. This was evident for one 1(Resident #1) out of 3 residents reviewed for accidents. Specifically, Resident #1 complained of pain to their right arm on 09/18/2025 and Xray results showed a non-displaced fracture of the right proximal humeral shaft. Resident #1 was unable to explain the occurrence. The incident was not reported to the New York State Department of Health within 2 hours of the Xray results. The findings are: The Facility policy titled Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property reviewed 08/2025 documented Abuse allegations (abuse, neglect, exploitation, or mistreatment, including injuries of unknown source without clinical baseline and misappropriation of resident property) are reported per Federal and State Law. The facility will ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than two (2) hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse or result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facility) in accordance with State Law through established procedures. Resident #264 had diagnoses of Non-Alzheimer's Dementia, Chronic Diastolic Heart Failure, and Polyneuropathy. The Annual Minimum Data Set, dated [DATE] documented Resident #1 had severely impaired cognition and required maximal assist with upper body dressing, personal hygiene, and roll left and right. Resident #1 was dependent of staff with the remainder of Activity of Daily Living care. Resident #1 was always incontinent of urine and bowels. The Comprehensive Care Plan related to pain effective 10/24/2021 and last updated 09/19/2025 documented Resident #1 will not verbalize pain/discomfort related to fragility of bone related to diagnosis of fracture and moderate osteoporosis x 90 days. Interventions included on-going assessment of the resident's pain with emphasis on the onset, location, description, intensity of pain and alleviating and aggravating factors and monitor side effects and adverse reactions resulting from interventions rendered. The Accident Investigation dated 09/19/2025 at 5:30PM documented Resident #1's next of Kin reported resident complained of right arm pain with movement on 09/18/2025. Certified Nursing Assistant #1's statement who worked 7:00 AM to 3:00PM on 09/18/2025 documented Resident #1 complained of, pain all over their body but not too much and they reported this to Licensed Practical Nurse #1. Nurse Practitioner #1 was notified on 09/18/2025 and ordered a right upper extremity Xray. The Accident investigation revealed this pain was not a result from Activity of Daily Living activity or a fall. On 09/19/2025 an Xray result of the right shoulder showed an acute nondisplaced fracture of the right proximal humeral shaft. Nurse Practitioner #1 ordered to transfer Resident #1 to the emergency room for further medical evaluation and management, and Resident #1 was sent to the emergency room at 5:33 PM. The Administrative Determination completed 10/09/2025 documented on 09/19/2025, at approximately 5:30 PM, a report was received from Registered Nurse #3 who was the supervisor on duty that Resident #1's right shoulder X-ray result revealed a non-displaced fracture of the right proximal humeral shaft. The day before, on 09/18/2025 Nurse practitioner #1 was informed Resident #1 complained of right arm pain. Nurse Practitioner #1 assessed resident at bedside, no distress noted, no swelling, no discoloration, no tenderness on palpation, no warmth, with no overt signs of infection. Nurse practitioner #1 ordered Tylenol 650 milligrams by mouth every 8 hours as needed, and a right upper extremity X-ray. Based on an interview with the next of kin who was at the bedside, they stated that Resident #1 expressed they had pain. Resident #1 did not have any incidence of falls and due to confusion was not able to give an account on the occurrence. Nurse practitioner #1 reviewed the X-ray results on 09/19/2025 and ordered to send Resident #1 to the hospital for further medical evaluation. Resident #1 was transferred to the emergency room on [DATE], at 5:33 PM and came back to the facility in stable condition on 09/20/2025 at 3:12 AM accompanied by their next of kin. Resident #1 returned with a sling on their right arm</p>		