STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335484	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morningside Nursing and Rehabilitation Center	1000 Pelham Parkway South Bronx, NY 10461

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** Based on observation, record review, and interviews during an abbreviated survey (2704295), the facility did not ensure that each resident received adequate supervision to prevent accidents. This was evident for one (1) out of three (3) residents (Resident #1) sampled for accidents. Resident #1 had severely impaired cognition, was assessed as high risk for falls, and had history of multiple falls. Specifically, Resident #1 experienced recurring falls on five occasions between 11/21/2025 and 01/05/2026. Despite these incidents, preventative supervision of Resident #1 was not documented in the care plan until after the fall on 01/05/2026 at 1:50 AM. There were no injuries noted in Resident #1's medical record because of the falls.The findings include:A facility's policy and procedure titled, Fall Prevention Program dated 06/2024, documented it is the policy of the facility to identify the fall risk of all residents and outline interdisciplinary interventions to prevent falls. The licensed nurse will screen all residents for all fall risk upon admission, quarterly, annually, and significant change and after each fall. A care plan for the prevention of falls will reflect interventions for fall prevention and injury reduction. Fall and Injury Prevention Plan documented collaboration, with interdisciplinary team members for implementation and evaluation of the individualized comprehensive care plan. Discuss safety risk levels in team conferences and identify specific strategies for fall prevention in the care plan. A facility's policy and procedure titled, Visual Checks dated 07/2013, documented it is the facility's policy that all nursing staff assigned to a unit shall participate in monitoring of the residents who are on visual checks. The nurse in charge will inform the nursing staff that a resident is to be observed and the frequency of the checks. Residents will be placed on visual checks as determined by the Interdisciplinary Care Plan Team or that are at risk for safety concerns as determined by the nurse in charge or supervisor. To monitor the residents in accordance with frequency schedule.A facility's policy and procedure titled Visual Checks dated 06/16/2020, documented room checks will be done on all shifts to help ensure that our residents' environment remains as free from accident hazards as possible and for each resident to receive adequate supervision and /or assistance. The Room Checks (also known as rounds) will establish the frequency of observing residents' activities and aim to prevent falls. During the designated time, Room Check or Rounds will be conducted on all residents in the unit. Hourly room checks will be done during the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shift. Half- hourly room checks are to be done during the 11:00 PM-7:00 AM shift. A facility's Policy and Procedure titled One-to-One Monitoring and Resident Supervision dated 03/18/2019, documented the facility does not provide one-to-one monitoring for fall prevention. Fall risk is managed through comprehensive assessment, individualized care planning, environment safety measures, staff supervision, and interdisciplinary interventions, rather than continuous individual observation. Resident #1 was admitted to the facility with diagnoses including malignant neoplasm of prostate, anemia, Non-Alzheimer's Dementia, and depression.The Minimum Data Set (an assessment (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	tool) dated 11/03/2025, documented Resident #1 cognition was severely impaired. Resident #1 required supervision or touching assistance with transfer and ambulation from bed-to-chair- to-bed. A Fall Risk assessment dated [DATE] documented Resident #1 was identified as high risk for fall. A review of the instructions for Certified Nursing Assistant (Kardex) dated 07/28/2025, revealed providing supervision/oversight to the resident at least once every hour. Observations were performed at set intervals to address the resident's needs, ensure safety, prevent accidents, and report any concerns to the nurse.An Accident Report dated 11/21/2025 at approximately 8:15 PM, documented Registered Nurse #1 observed Resident #1 sitting on the floor on the right side of their wheelchair. Resident #1 was assessed by Registered Nurse Supervisor #1. There was no visible injury. Resident #1 verbally complained of back pain and the pain was 3/10 on the pain scale. The Medical Doctor #1 and the Emergency Contact #1 were notified. Pain medication was given with effect. A Lumbosacral Spine x-ray revealed a diagnosis of osteopenia (condition characterized by lower-than-normal bone mineral density, which can lead to an increased risk forf fracture), scoliosis (condition characterized by an abnormal side-to-side curvature of the spine), and spondylosis (degenerative changes in spine) noted with immediate degenerative disc disease. No fractures were identified. The facility's plan included to remind Resident #1 to ask for assistance, use call bell for assistance, keeping personal items and call bell within reach, and maintain half hour visual checks through purposeful room checks or rounding. The facility's investigation concluded that no abuse or neglect occurred, and the incident was unavoidable. An Accident Report dated 12/08/2025 at approximately 9:17 PM, documented Certified Nursing Assistant #1 observed Resident #1 lying on the floor, inside their room. Resident #1 was assessed by Registered nurse Supervisor #2. There was no visible injury. Resident #1 complained of lower back pain. The medical doctor and the emergency contact #1 were notified. Pain medication was given and was effective. Lumbosacral and bilateral hips were ordered. The x-ray result revealed mild degenerative changes in the left hip and degenerative changes in lumbosacral spine. There were no fractures. The facility's plan included to maintain bed in lowest position and to maintain half hour visual checks through purposeful rounding. The facility's investigation concluded that no abuse or neglect occurred, and the incident was unavoidable most likely due to behavioral habits of non-compliance and self-autonomous acts.An Accident Report dated 12/16/2025 at approximately 6:40 PM, documented while Registered Nurse Supervisor #3 was conducting rounds they observed Resident #1 lying on the floor, at the left side of the bed. There was no visible injury. Resident #1 reported pain in their left knee and elbow. A pain patch was applied to left knee and elbow. The pain medication was given and effective. Medical Doctor #1 and the Emergency Contact #1 were notified. An x-ray of the left knee and left elbow were ordered. The x-ray result showed the left knee was normal no fractures or dislocation. The left elbow showed normal alignment without fracture or dislocation. The facility's plan included to maintain bed in lowest position and maintain half hour visual checks through purposeful rounding. The facility's investigation concluded there was no abuse or neglect occurred.An Accident Report dated 12/29/2025 at approximately 11:07 AM, documented Resident #1 was taken to their room after their breakfast for incontinent brief change and refused to go back to dining room. Resident #1 was placed comfortably in bed and instructed to use call bell when needed assistance. At 11:07 AM, Housekeeping Aide #1 observed Resident #1 sitting on the floor in their room beside their bed and notified Registered Nurse #4. Resident #1 stated they tried to grab some food and lost their balance. Resident #1 was assessed by Registered Nurse #4. The Medical Doctor #1, and the emergency contact #1 were notified. Emergency Contact #1 requested hospital transfer for an evaluation. Resident #1 returned from emergency department visit with primary diagnoses of urinary tract infection and acute kidney injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's plan included to maintain bed in lowest position and maintain half hour visual checks through purposeful rounding. The facility's investigation concluded that no abuse or neglect occurred, and the incident was unavoidable most likely due to behavioral habits of non-compliance and self-autonomous acts.An Accident Report dated 01/05/2026 at approximately 1:50 AM, documented Certified Nursing Assistant #5 observed Resident #1 ambulating near their room door in the hallway while holding the handrails, Certified Nursing Assistant #5 ran but unable to reached Resident #1. Resident #1 lowered themselves on the floor in a sitting position. Resident #1 was assessed by Registered Nurse Supervisor #1. There was no visible injury. Resident #1 did not complain of pain. The emergency contact #1 and #2 were notified. The medical doctor #1 was notified and ordered stat (immediately) bilateral x-ray, bilateral hip, urine analysis and culture and sensitivity, complete blood count, complete metabolic panel, hemoglobin A1C, stat echocardiogram (ultrasound to create images of the heart), stat orthopedic appointment and to send Resident #1 to hospital for further evaluation. Emergency Contact #1 was notified and refused hospital transfer. An x-ray results of left knee showed no acute fractures, right knee showed mild osteopenia, lumbosacral spine showed no acute fracture and with degenerative changes and bilateral hips showed mild arthritic changes without obvious fracture. The facility's plan included to maintain bed in lowest position and maintain half hour visual checks through purposeful rounding. The facility's investigation concluded that no abuse or neglect occurred, and the incident was unavoidable most likely due to behavioral habits of non-compliance and self-autonomous acts.A review of the Accident Reports dated 11/21/2025 through 01/05/2026 the facility's plan to maintain half hour visual checks through purposeful rounding was not implemented in Resident #1's care plan.A review of fall care plan revealed there was no documented evidence of supervision reflected in Resident #1's care plan to implement adequate supervision until after the fall in 01/05/2026 at 1:50 AM.A review of Daily Resident Room Check (rounds) dated 11/21/2025, 12/08/2025, 12/16/2025, 12/29/2025 revealed Resident #1 was on hourly monitoring. An hourly monitoring (1 hour) was not reflected in the care plan.A review of Daily Resident Room Check (rounds) dated 01/05/2026 revealed Resident #1 was on half hour (30 minutes) monitoring. A half hour monitoring (1/2 hour) was not reflected in the care plan.During an interview on 01/06/2026 at 10:00 AM, the Emergency Contact #1 stated they made numerous complaints to the facility. Emergency Contact #1 stated Resident #1 had fall accidents on 11/25/2025, 12/08/2025, 12/16/2025, 12/29/2025 and 01/05/2026. Emergency Contact #1 stated despite their questions to Medical Doctor #1 and Director of Nursing there was no explanation for the fall incidents. Emergency Contact #1 stated they always tell them that they found Resident #1 on the floor. Emergency Contact #1 stated they asked the facility to implement fall prevention tactics and maybe Resident #1's dementia was worsening. Emergency Contact #1 stated they can conclude that facility was unable to provide supervision for Resident #1. Emergency Contact #1 stated there were no updated instructions in Resident #1's care plan.During an interview on 01/12/2026 at 3:39 PM, Certified Nursing Assistant #1 stated they were the regular assigned staff when Resident #1 had fall incidents during the evening shift (3:00 PM-11:00 PM). Certified Nursing Assistant #1 stated they monitor Resident #1 every hour along with all other residents on the unit during their shift . Resident #1 had more frequent visual checks because Resident #1 was a high risk for fall. Certified Nursing Assistant #1 stated they could not describe what more frequently meant but could be every 30 minutes. Certified Nursing Assistant #1 stated they do not document when Resident #1 was monitored more frequently. Certified Nursing Assistant #1 stated there were no specific orders or instructions for more than hourly rounds. Certified Nursing Assistant #1 stated Resident #1 had aggressive behavior and combative behavior of pushing and hitting them and Resident #1 tells them to leave them alone. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified Nursing Assistant #1 stated there were no more activities going on after dinner in the day room During an interview on 01/14/2026 at 7:59 AM, Certified Nursing Assistant #6 stated they worked the night shift (11:00 PM-7:00 AM) on 01/05/2026. Certified Nursing Assistant #6 stated during their shift Resident #1 was monitored every 30 minutes as with the other residents. Certified Nursing Assistant #6 stated when they arrived on the unit, they saw Resident #1 pacing back and forth in the hallway. Certified Nursing Assistant #6 stated when Resident #1 was sleepy in their wheelchair, they put them to bed and later, they observed Resident #1 trying to get up unassisted. Certified Nursing Assistant #6 stated when Resident #1 was restless they watched them in the nursing station and offered them snacks. Certified Nursing Assistant #6 stated Resident #1 was now monitered every 15 minutes to prevent from fall.During an interview on 01/12/2026 at 11:19 AM, Registered Nurse Supervisor #3 stated they were doing their rounds on the unit on 12/16/2025 at 6:40 PM when they saw Resident #1 lying on the floor on the left side of their bed. Registered Nurse Supervisor #3 stated they assessed Resident #1 and there was no visible injury. Registered Nurse Supervisor #3 stated prior to the incident Resident #1 was observed by staff wheeling themself to their room and wanted to stay in room and go to bed. Registered Nurse Supervisor #3 stated they updated the care plan. Registered Nurse Supervisor #3 stated although Resident #1 was on hourly monitoring during the day shift and evening shift, staff were encouraged to check Resident #1 more frequently. Registered Nurse Supervisor #3 stated when they say more frequently, they do not have specific time, but they visually check Resident #1 more often but not documented. Registered Nurse Supervisor #3 stated they noticed the hourly monitoring for day shift and evening shift and half hour monitoring for night shift was not documented in Resident #1's care plan. Registered Nurse Supervisor #3 stated they do not know why there were no documentations.During an interview on 01/14/2026 at 8:32 AM, Registered Nurse Supervisor #2 stated they were notified on 12/08/2025 at 9:17 PM by Registered Nurse #2. Registered Nurse Supervisor #2 stated Resident #1 was assessed and there was no visible injury. Registered Nurse Supervisor #2 stated they have lists of residents that are at a high risk for fall in each unit and staff were aware. Registered Nurse Supervisor #2 stated they update and reflected the incident in the care plan and check interventions. If needed new intervention are included. Registered Nurse Supervisor #2 stated their Risk Management #1 (Assistant Director of Nursing #1) in the morning received and reviewed incident reports and reviewed the care plan interventions. Registered Nurse Supervisor #2 stated, them and the unit nurses were responsible for ensuring staff implementing the care plan interventions.During an interview on 01/14/2026 at 8:57 AM, Registered Nurse Supervisor #4 stated they were notified of the incident on 12/29/2025 at 11:07 AM. Registered Nurse Supervisor #4 stated they assessed Resident #1 and there were no visible injury. Registered Nurse Supervisor #4 stated they provide adequate supervision to Resident #1 by keeping them in the day room, frequent visual checks hourly during the day and evening and half an hour in the night shift. Registered Nurse Supervisor #4 stated they believed Resident #1 had adequate supervision by keeping them in the day room with a certified nursing assistant assigned.During an interview on 02/02/2026 at 11:01 AM, Registered Nurse Supervisor #1 stated they worked on 11/21/2025 and 01/05/2026 during the incidents. Registered Nurse Supervisor #1 stated they assessed Resident #1 and there were no visible injuries. Registered Nurse Supervisor #1 stated they had monitoring log for each shift. Registered Nurse Supervisor #1 stated incidents are documented in the care plan with interventions. Registered Nurse Supervisor #1 stated the Risk Manager (Assistant Director of Nursing #1) will review incidents and the care plan interventions. Registered Nurse Supervisor #1 stated Resident #1 was closely supervised by staff by checking them more frequently like every 5 minutes because Resident #1 had history of multiple falls. Registered Nurse (continued on next page)

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