

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335486	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2025
NAME OF PROVIDER OR SUPPLIER Pelham Parkway Nursing Care & Rehab Facility L L C		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 Laconia Ave Bronx, NY 10469	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on observation, record review, and interviews conducted during an Abbreviated Survey (NY00344413 and NY00376155), the facility failed to report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This was evident in two (2) out of seven (7) residents (Resident #3 and #5) sampled. Specifically, on 05/30/2025 at 9:30 AM, Resident #3 was escorted by Certified Nursing Assistant #6 for clinic appointment and Resident #3 had an accident by sliding off from wheelchair in the vehicle. Certified Nursing Assistant #6 did not report the incident to anyone at the facility. On 05/31/2025 at 11:35 AM, Resident #3 told Registered Nurse Supervisor #1 on 05/30/2024 an incident occurred while being transported to an appointment. Registered Nurse Supervisor #1 assessed Resident #3 and there were no signs of injuries. On 06/02/2025 at 11:00 AM, Resident #3 went out on pass with family and returned to the facility at 9:20 PM. On 06/03/2024 at 1:27 PM, Resident #3 complaint of burning and tingling to their left leg and foot. In the Nurse Practitioner notes dated 06/04/2024 at 1:02 PM, documented Resident #3 was observed with bilateral knee bruises and redness. An x-ray of the right and left knee was ordered, and the result was received at approximately 10:10 PM which documented Resident #3 had an acute fracture of both knees and osteopenia. Resident #3 was transferred to the hospital. The facility did not report timely to the New York State Department of Health and did not submit the follow up investigation within five days. On 03/24/2025 at 7:30 PM, Resident # 5's Residential Case Manager visited the facility and informed Registered Nurse Supervisor #2 that Resident #5 alleged they were abused and attacked by multiple staff members. The facility investigated and reported the incident to New York State Department of Health on 03/25/2025 at 6:09 PM, and did not report the allegation to local law enforcement.</p> <p>The findings are:</p> <p>The facility's policy and procedure titled Abuse Prevention dated 10/03/2023, documented that all findings of investigations will be documented. An investigative report will be completed within 5 days and summarize the findings and outcome as well as any corrective action(s). If abuse cannot be ruled out the New York State Department of Health will be notified.</p> <p>Resident #3 was admitted to the facility with diagnoses including morbid obesity, spina bifida (a congenital defect of the spine in which part of the spinal cord is exposed through a gap in the backbone, often causing paralysis of the lower limbs).</p> <p>The Minimum Data Set (an assessment tool) dated 03/02/2024, documented Resident #3 was assessed with intact cognition.</p> <p>(continued on next page)</p>

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>The facility Summary of Investigation dated 06/06/2024, documented Resident #3 reported to Registered Nurse Supervisor #1 on 05/31/2024 at 11:35 AM that on 05/30/2024 during their transport to their appointment, the driver suddenly stopped, and Resident #3 moved forward in their wheelchair but did not fall. Resident #3 was assessed by Registered Nurse Supervisor #1 on 05/31/2024 there were no injuries. Resident #3 denied pain. Certified Nursing Assistant #6 was interviewed, and they stated Resident #3 slid slightly forward in their wheelchair and was repositioned. Resident #3 did not fall. On 06/04/2024, Resident #3 was observed with bilateral knee redness, and swelling of lower extremities. An x-ray was ordered on bilateral knee and left leg. The x-ray result of left and right knee revealed acute fracture and osteopenia. The facility's investigation concluded that there was no abuse or neglect occurred. The incident was reported to the New York State Department of Health on 06/05/2024 at 2:19 PM.</p> <p>There was no documented follow up report submitted to New York State Department of Health within five (5) days.</p> <p>Resident #5 was admitted to the facility with diagnosis including thyroid disorder, bipolar and depression.</p> <p>The Minimum Data Set (an assessment tool) dated 01/16/2025, documented Resident #5 had intact cognition.</p> <p>In a Nursing Note dated 03/24/2025 at 8:24 PM, Registered Nurse Supervisor #2 documented at approximately 8:00 PM, they responded to Resident #5 's unit to speak with Resident #5's Residential case manager. Resident #5's Residential case manager informed Registered Nurse Supervisor #2 that they received a call from Resident #5 stating that they were attacked by two (2) Certified Nursing Assistants in their room and as a result, they sustained scratch marks to their right cheek. Registered Nurse Supervisor #2 reassessed Resident #5 and observed some scratch mark on their right cheek.</p> <p>The Facility Summary of Investigation dated 03/26/2025 documented Resident #5 had behavior of fabricating stories being accusatory towards staff and peers. Investigation summary further documented Resident #5's allegation could not be substantiated due to inconsistencies in interviews and the alleged incident was not in areas of surveillance footage.</p> <p>A Webform Submission from the Nursing Home Facility Incident Report showed that the facility submitted their incident report to New York State Department of Health on 03/25/2025 at 6:09 PM.</p> <p>During an interview on 06/04/2025 at 1:20 PM, the Director of Nursing stated they were involved in the investigation, but it was the previous Director of Nursing who does the reporting and submission of five (5) day report to the New York State Department of Health. The Director of Nursing stated they were not aware that the follow up investigation of incident dated 05/31/2024 was not submitted to New York State Department of Health within 5 days.</p> <p>During an interview on 06/04/2025 at 3:40 PM, the Administrator stated they were not aware that the five (5) day report was not submitted to New York Stated Department of Health. The Administrator stated that the completed investigation should have been submitted to the Department of Health within 5 business days.</p> <p>(continued on next page)</p>

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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>During an interview on 06/05/2025 at 12:25 PM, Registered Nurse Supervisor #2 stated on 03/24/2025 at 8:00 PM they met with Resident #5's Residential Case Manager on the unit and they reported to Registered Nurse Supervisor #2 that Resident #5 told them they were attacked by two (2) Certified Nursing Assistants in their room and sustained a scratch mark on their right cheek. Registered Nurse Supervisor #2 stated the Director of Nursing, and the Medical Doctor were informed that same night on 03/24/2025, they can't recall the time.</p> <p>During an interview on 06/11/25 at 2:03 PM, the Director of Nursing stated on 03/24/2025 at approximately 8:15 PM, they received a call from Registered Nurse Supervisor #2 stating that Resident #5's Residential Case Manager reported that Resident #5 told them that they were attacked by staff. The Director of Nursing stated at approximately 8:20 PM, they called the Administrator and informed them of the information provided by Registered Nurse Supervisor #2 and based on their conversation they agreed to further investigate the concern in the morning because Resident #5 has history of fabricating stories. The Director of Nursing stated after they and the Administrator reviewed the surveillance footage on 03/25/2025 and interviewed Resident #5 and other staff members, they reported the allegation of abuse to the Department of Health. The Director of Nursing stated they are aware that any allegation of abuse should be reported to the Department of Health within 2 hours, however they and the Administrator agreed to review the surveillance video footage before reporting to the New York State Department of Health. The Director of Nursing stated that the local law enforcement was not contacted.</p> <p>During an interview on 06/06/2025 at 12:20 PM, the Administrator stated they received a call from the Director of Nursing on 03/24/2025 at approximately 8:00 PM that Resident #5 had an aggressive behavior with a staff. The Administrator acknowledged that the Department of Health was informed on 03/25/2025.</p> <p>10 NYCRR 415.4 (b)(1)(ii)</p>		