

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 12/04/2025
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)
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 record review, and interviews conducted during the abbreviated survey (#2622204), 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 caused the allegation involve abuse or result in serious bodily injury, or no 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) of one (1) (Resident #1) sampled. Specifically, Resident #1 had an unwitnessed incident on 09/06/2025 when they were observed on the floor and noted with swelling to the forehead, left peri-orbital (area around the eye) swelling and an abrasion on the nose. Resident #1 was unable to explain the occurrence and the incident was not reported to the New York State Department of Health. The findings are: The facility's policy titled 'Accident and Incident (A/I) Investigation and Reporting' last revised 12/04/2024 documented the facility must 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 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 and do not 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 facilities) in accordance with State law through established procedures. Resident #1 had a diagnosis of Epilepsy and Alzheimer's Disease. The Comprehensive Care Plan titled 'Actual Falls/Accident/Incident' initiated on 10/01/2024 documented Resident #1 has a diagnosis of epilepsy. Interventions included to keep the bed in the lowest position and keep call bed within reach. The Registered Nurse Supervisor Progress Note dated 09/06/2025 documented the Registered Nurse responded to staff call on the floor and observed Resident #1 on the floor by the left side of the bed in left side position. Upon Registered Nurse's assessment, Resident #1 was unable to narrate incident due to cognitive impairment. Observed slight swelling of the forehead, left peri-orbital swelling and abrasion on the bridge of the nose. No change in mentation. Range of Motion intact to upper extremities and left lower extremity. Percocet administered routinely for pain management. Patient was assisted back to bed by 4 assist. Doctor notified with recommendation to transfer Resident #1 to the hospital. The Accident Investigation Report dated 09/06/2025 documented time of report at 4:30PM. Resident #1 was observed to be alert and verbally responsive, unable to explain incident, noted with slight swelling on forehead, left periorbital swelling and ecchymosis in addition to slight abrasion on the bridge of the nose. No change in mental status and no loss of consciousness observed. The plan included to transfer the resident to the hospital for CT scan of the face. There was no documented evidence the facility reported Resident #1's unwitnessed incident to the New York State Department of Health. On 10/31/2025 at 3:37 PM, the Director of Nursing [NAME] was interviewed and stated there was an unwitnessed event where Resident #1 was found on the floor on 09/06/2025, and as Resident #1 was found on the floor, it was attributed to a fall because there was no one else present in the room with Resident #1 at that time. The Director of Nursing also stated Resident #1 sustained an abrasion to the nose and was transferred to the hospital. The Director of Nursing Services further stated injuries of unknown origin are called in to the Department of Health, however, in this case, since there was no fracture, it was not a major injury which was reportable to the state. On 10/31/2025 at 3:42 PM, the Medical Doctor was interviewed and stated injuries with fractures and questionable abuse are reported to the Department of Health. The Medical Doctor also stated if a resident is seen on the floor, then it is assumed that they sustained a fall. The Medical Doctor further stated if a resident was seen lying on the bed with bruises, then that is a different scenario and would warrant a call to the Department of Health. On 11/03/2025 at 10:06 AM, the Administrator was interviewed and stated major injuries, suspected abuse, and injuries of unknown origin with major injury are reportable to the Department of Health. The Administrator also stated this incident was not reported to the state because it was attributed to a fall. The Administrator further stated Resident #1 has been at the facility a long time, has a history of falls, and has a room right by the nursing station with a roommate that was bedbound at the time the incident occurred. The Administrator stated the incident also occurred during daylight hours which all points to the fact that the injury was due to a fall and at that time Resident #1 also had a history of trying to walk when they were supposed</p>		