STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335486	A. Building B. Wing	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pelham Parkway Nursing Care & Rehab Facility L L C	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations and staff interviews conducted during the Recertification survey, the facility did not ensure that each resident was treated with respect, dignity and care in a manner that promotes maintenance or enhancement of their quality of life and recognizes each resident's individuality. This was observed on five (5) out of five (5) units observed during the kitchen and Dining Observation Task. Specifically, the residents' meals were served on disposable dishware with plastic cutlery.The findings are: The facility policy titled Dining, with effective date January 3, 2024, stated food will be prepared and served in a manner that meets the individual needs of the resident. The facility policy titled Home Life, Safe, Clean and Comfortable Environment, reviewed October 15, 2024, stated it is the policy of the facility to provide a safe, clean, comfortable homelike environment in such a manner to acknowledge and respect resident rights to the extent possible. This includes but is not limited to residents will be provided with regular cutlery and dishes unless otherwise indicated. A list of residents who are to receive disposable plates and cutlery documented a total of 16 residents: 4 residents on Unit 1, 6 residents on Unit 2, 4 residents on Unit 3, 1 resident on Unit 4, and 1 resident on Unit 5.On 08/19/2025 at 12:08 PM and 08/20/2025 at 12:15PM, during lunch observation on Unit 2, with the exception of puree meals, all other residents' meals were observed served on Styrofoam plates. All residents were observed eating with plastic utensils. On 08/22/2025 at 3:50 PM, during a Kitchen Observation, all residents' trays were observed set up on tray trucks for the dinner meal. All trays were observed with plastic utensils. On 08/22/2025 at 4:00PM, an interview was conducted with the Food Service Director who stated the facility does not have any metal silverware, and they have never seen metal silverware in the facility since their hire in December 2024. The Food Service Director also stated they were told the metal silverware was used by residents with behavioral issues to potentially hurt each other, and other residents were hoarding the silverware. The Food Service Director further stated since their hire in December 2024, the facility has not had enough China plates because they were chipped, broken and hoarded by the residents and not replaced, so Styrofoam plates are used. The Food Service Director stated the facility should provide metal silverware and China plates to sustain or improve the resident's quality of life and that they have a list of the residents who should receive Styrofoam plates and plastic utensils for safety. Those resident's names are provided by nursing, and disposable silverware is documented on those meal tickets as they are the only residents who should be served Styrofoam plates and plastic utensils.On 08/25/2025 at 4:01 PM, an interview was conducted with the Administrator who stated there must have been a misunderstanding with the new Food Service Director regarding plates and flatware as not all residents should be eating on Styrofoam plates and using plastic utensils. The Administrator also stated there had been an issue with residents hoarding dishes and residents with behavioral issues were placed on a list not to receive metal utensils but other than that everyone else should have been served with regular plates and metal utensils. 10 NYCRR 415.5

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interviews, observations and record reviews conducted during a recertification survey, the facility did not ensure that a comprehensive care plan was developed within 7 days after completion of the comprehensive assessment. This was evident for one (Resident #192) of five residents sampled for Unnecessary Medications. Specifically, Resident #192 was taking medication for Gastrointestinal issues and there was no care plan in place. The findings are:The facility's policy and procedure entitled Resident Care Plans, last reviewed 02/05/2025, states that each resident will have an individualized interdisciplinary plan of care developed within 21 days of admission and reviewed and revised on a quarterly basis.Resident #192 was admitted to the facility with diagnoses including Vascular Dementia, Psychotic Disorder and Gastroesophageal Reflux Disease with Esophagitis.The Annual Minimum Data Set (a resident assessment tool) dated 03/20/2025 lists Resident #192's active diagnoses as Gastroesophageal Reflux Disease, Non-Alzheimer's Dementia, Depression and Psychotic Disorder. The Physician orders dated 08/12/2025 documented Resident #192 was prescribed Pantoprazole 40 mg once a day for Gastroesophageal Reflux Disease. There was no documented evidence a care plan was created for Resident #192 to address care of a resident with a diagnosis of Gastroesophageal Reflux Disease.On 08/25/2025 at 1:43 PM, Registered Nurse Supervisor #1 was interviewed and stated they usually enter the care plans into the electronic medical record, and a Gastrointestinal Status care plan had not been initiated for Resident #192. Registered Nurse Supervisor #1 also stated they were new to the facility and had not reviewed Resident #192's medical diagnoses when reviewing their care plans but had just followed what was in place before.On 08/26/2025 at 12:32 PM, the Director of Nursing was interviewed and stated upon admission, each resident's medications are reconciled with the physician, the nurse supervisor, the Minimum Data Set department and themself. The Director of Nursing also stated Resident #192 was taking Pantoprazole and therefore had symptomatic Gastroesophageal Reflux Disease, so a care plan for Gastrointestinal Status would be appropriate. The Director of Nursing further stated it was possible the care plan could have been discontinued for some reason, but it should have been included within Resident #193's comprehensive plan of care.10NYCRR 415.11(c)(2)(i-iii)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview conducted during the Recertification survey, the facility did not ensure that the resident's comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment, including both the episodic, comprehensive, and quarterly review assessments. This was evident for one resident (Resident #8) reviewed for Hospice and one resident (Resident #192) reviewed for Unnecessary Medications out of an investigative sample of 38 residents. Specifically, 1). The care plan related to Hospice for Resident #8 was last reviewed on 04/09/2025, and 2). Resident #192's care plan related to Cognitive loss was last reviewed on 01/03/2025, the care plan related to Social Isolation was last reviewed on 10/22/2024, and the care plan related to psychosocial well-being was last reviewed on 07/22/2024. The findings are: The facility policy and procedure titled Resident Care Planning, last revised on February 5, 2025, stated each resident will have an individualized, interdisciplinary plan of care in place per federal regulations. The comprehensive care plan will be reviewed and revised every quarter upon a significant change in condition, upon readmission from an inpatient hospital stay, and as required by the resident or resident representative. 1.Resident #8 was admitted with diagnoses that include Alzheimer's Disease and Hypertension The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #8's cognition was severely impaired, they never/rarely made decisions, and was on Hospice Care. The Medical Doctor's Order dated 09/29/2024 documented Hospice care. A comprehensive care plan related to Hospice Care was initiated for Resident #8 on 10/01/2024. There was no documented evidence that the care plan was reviewed and revised after the quarterly assessment on 06/27/2025. On 08/25/2025 at 2:28 PM, Registered Nurse #1, the supervisor, was interviewed and stated the hospice care plan was implemented on 10/01/2024 and was last updated on 04/09/2025. Registered Nurse #1 also stated care plans are updated every three months, and it is the Social Worker's responsibility to update the Hospice care plan and ensure that it is reviewed and revised every quarter. On 08/25/2025 at 3:21 PM, Social Worker #1 was interviewed and stated that they initiated the hospice care plan, and it is usually the Social Worker's responsibility to update the hospice care plan. Social Worker #1 also stated care plans are reviewed and revised every three months, and accordingly if there are changes. Social Worker #1 further stated revision of this care was due sometime in July, and they might have missed it. On 08/26/2025 at 8:24 AM, the Director of Nursing was interviewed and stated that care plans are reviewed and revised quarterly, annually, for significant changes, and at the start of medication. The Director of Nursing also stated the supervisors on the floor are required to renew the nursing aspect of the care plan, and each department is responsible for its care plan. The Director of Nursing further (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated Social Services is supposed to renew the hospice care plan, and the director of each department is supposed to ensure the care plans are revised accordingly. 2. Resident #192 was admitted to the facility with diagnoses including Anxiety Disorder, Mood Disorder, Psychotic Disorder, and Vascular Dementia. The Minimum Data Set (a resident assessment tool) dated 03/20/2025 lists Resident #192's active diagnoses as Non-Alzheimer's Dementia, Depression, Psychotic Disorder, and Mood Disorder. Review of Resident #192's comprehensive plan of care revealed the Cognitive Skills for Daily Decision-Making care plan was last updated on 01/03/2025, the Mood State, the Psychosocial Well-being, and the Discharge Planning care plans were last reviewed on 07/22/2024, the Advance Directives care plan was last reviewed on 04/22/2024, and the Social Isolation/Loneliness Care Plan was last reviewed on 10/22/2024. On 08/25/2025 at 10:38 AM, Social Worker #1 was interviewed and stated they are responsible for updating all care plans related to psychosocial functioning every three months within one week of each resident's care plan meeting. Social Worker #1 also stated Resident #192 had care plan meetings on 01/03/2025, 03/27/2025 and 06/16/2025 but they were working alone as the only Social Worker in the building up until July 2025 and there were some things that just did not get done. Social Worker #1 further stated they are supervised by the Director Social Services, but that position had been vacant, and the new Director has only been here for a couple of months, so nobody noticed these care plans had not been revised. On 08/26/2025 at 2:20 PM, the Director Social Services was interviewed and stated that they began working in the facility in July 2025. The Director Social Services also stated that responsible staff know when to update care plans by following the Assessment Reference Dates on the Minimum Data Sets and that with appropriate time management, it should be possible to update the care plans even when working alone. The Director Social Services further stated that they are responsible for reviewing the care plans to make sure that those involving psychosocial issues are updated by the Social Worker and that they had not noticed that Resident #192's had not been recently updated. 10 NYCRR 415.11(c)(2)(i-iii)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during the Recertification survey, the facility did not ensure that medical records were maintained in accordance with accepted professional standards and practices and that they were complete and accurately documented for each resident. This was evident for one (Resident #57) of five residents reviewed for Unnecessary Medication and one (Resident #174) of five residents reviewed for Pressure Ulcer/Injury) out of 85 total sampled residents. Specifically, 1). A care plan for schizophrenia was documented for Resident #57 who does not have a schizophrenia diagnosis, and 2). The Treatment Administration Records for Resident #174 documented nursing staff performed wound care when Resident #174 refused to allow the facility staff to perform the treatments. The findings include: The facility policy and procedure titled Accurate Medical and Clinical Record Documentation, revised January 2025, stated it is the policy of the facility to provide accurate medical and clinical documentation. All facility staff who document in the medical record and/or clinical records will be responsible to ensure their documentation is accurate and dated correctly. All medical and nursing services provided should be accurately documented in the medical record by the individual providing services. Staff may only document services or tasks that they have personally provided for a Resident. Staff may only document the completion of medical or clinical services or tasks provided for the Resident. All services or tasks provided by staff should be verified by providing an electronic signature that the medical or clinical services were provided. 1). Resident #57 was admitted to the facility with diagnoses including Dementia and Schizophrenia. The admission Minimum Data Set assessment dated [DATE], documented that Resident #57 had moderately impaired cognition for daily decision making, had active diagnoses of non-Alzheimer's dementia and Schizophrenia and was administered antidepressant and antipsychotic medications. An admission Face sheet dated 04/28/2022, documented Resident #57 had diagnoses of Unspecified dementia and Psychotic disorder. A Psychiatric Initial Consultation Note dated 05/11/2022, documented Resident #57 had diagnoses which included Dementia, Depression and Adjustment disorder. A Physician Assessment Form/Progress Note dated 06/01/2022, documented Resident #57 with diagnoses of Dementia and Depression. The Quarterly Minimum Data Set assessment dated [DATE], documented Resident #57 had severely impaired cognition for daily decision making, had active diagnoses of non-Alzheimer's dementia with insomnia and was administered antidepressant medications. The Comprehensive Data Set assessment dated [DATE] documented Resident #57 had severely impaired cognition for daily decision making, had active diagnoses of Non-Alzheimer's dementia with insomnia, Depression and Psychotic Disorder (other than schizophrenia), and was administered antidepressant and antipsychotic medications. A Schizophrenia care plan with a creation and onset date of 08/18/2025, documented Resident #57 had a diagnosis of Schizophrenia as diagnosed by a qualified practitioner. A Psychotropic Medication Care Plan Note dated 07/17/2025 documented Resident #57 was seen by the in-house psychiatrist for follow up on current diagnoses of Dementia, Depression, and Psychotic disorder. On 08/25/2025 at 1:40 PM, an interview was conducted with the Director of Nursing who stated that an audit was performed for residents who had a diagnosis of schizophrenia. The audit was to ensure that schizophrenia care plans are in place and updated. The Director of Nursing also stated that Resident #57 came up on the list during the audit as having a diagnosis of Schizophrenia. The Director of Nursing further stated that Resident #57 was diagnosed with schizophrenia on 05/11/2022 at admission. The schizophrenia diagnosis was removed by the psychiatrist on 08/07/2023, but the Care Plan was added in error on 08/18/2025 following the audit.On 08/25/2025 at 1:53 PM, An interview was conducted with the Minimum Data System Coordinator who that Resident #57 was admitted in May 2022 with the antipsychotic medication Seroquel and once the diagnosis is in an MD progress note at admission the diagnosis of (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	schizophrenia is added to the admission Minimum Data Set assessment. The Minimum Data System Coordinator also stated Resident #57 was found not to meet the criteria for the diagnosis in August 2022, and so the diagnosis was not carried over in the ongoing assessments. The Minimum Data System Coordinator further stated Resident #57 never had a schizophrenia care plan in the medical record until 08/18/2025. 2). Resident #174 was admitted to the facility with diagnoses including Peripheral Vascular Disease and three venous or arterial ulcers.The Quarterly Minimum Data Set assessment dated [DATE], documented Resident #174 had moderately impaired cognition for daily decision making, had active diagnoses of Peripheral Vascular Disease and one surgical wound. On 08/20/2025 at 12:46 PM, Resident #174 was observed with an ace wrap dressing to the left lower leg. A Wound Care plan with onset date of 02/16/2024 documented a skin graft failure/venous stasis ulcer to the left lower leg. A Waiver/Choice of Treatment Form dated 10/31/2024 documented Resident #174 refused weekly wound rounds by the physician and daily wound care. The Medication and Treatment Administration Records dated 07/01/2025 to 08/26/2025 documented check marks that the Left shin treatment: Cleanse left medial shin with normal saline, apply Calcium alginate with Medi honey and cover with a dry protective dressing was completed daily from 07/01/2025 -07/31/2025 and 08/01/2025 to 08/19/2025. On 08/20/2025 at 12:46 PM, Resident #174 was interviewed and stated they perform the dressing change to the left leg because they are not happy with the performance of the facility staff. On 08/22/2025 at 12:36 PM, Resident #174 refused left leg wound observation and dressing change by Registered Nurse #1. On 08/25/2025 at 3:36 PM, an interview was conducted with Registered Nurse #1, the nursing supervisor, who stated they review the residents' care plans and not the Medication and Treatment Administration Records. Registered Nurse #1 also stated the nursing staff is entering a checkmark in the Treatment Administration Records which indicates they have performed/completed the treatments. Registered Nurse #1 further stated Resident #174 performs their own wound treatment and in most cases the nurses have not observed the resident perform the treatment. On 08/25/2025 PM, an interview was conducted with the Director of Nursing who stated that the check mark entries in the Medication and Treatment Administration Record document the treatment has been completed. The Director of Nursing also stated Resident #174 refuses to allow staff to perform the treatment and the nursing staff sometimes observe the treatment being performed. The Director of Nursing further stated Resident #174 performs the treatment but the nurse documents that it is completed in the Treatment Administration Records. 10 NYCRR 415.22(a)(1-4)

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during the Recertification Survey from 08/19/2025 to 08/26/2025, the facility did not ensure that residents' right to a clean, comfortable, and homelike environment was maintained. This was evident on 3 units (Unit1, Unit 2, and Unit 4) out of 5 units observed during the Environmental Task. Specifically, 1). On Unit 1 doors to the foyer and utility room were observed with multiple large areas of chipped and scrapped paint. The wall of the pull station was observed with dried uneven plaster, and the first-floor conference room windowsills were observed with peeling tape and 1 ripped window shade. 2) On Unit 2, multiple resident rooms were observed with broken and or missing slats from vertical blinds. The ceiling in room [ROOM NUMBER] was observed brown stained with peeling paint and a cracked window. The Unit 2 Dining room contained 1 missing window covering and the adjacent wall was unevenly plastered and unpainted. 3) On Unit 4, room [ROOM NUMBER] was observed with missing slats on the vertical blinds, a dirty air conditioner grill was observed attached to the unit with paper tape, and television remote control did not work properly. The findings include but are not limited to: The facility policy titled Home Life: Safe, Clean, and Comfortable Environment reviewed October 15th, 2024, stated it is the policy of the facility to provide a safe, clean, comfortable homelike environment in such a manner to acknowledge and respect resident rights to the extent possible. This includes but is not limited to: ensuring the resident can receive care and services safely and the physical layout of the facility maximizes resident independence and does not pose a safety risk. Providing housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. During multiple observations from 08/19/2025 through 08/26/25, the following were observed: 1). In Unit 1, doors to the foyer and utility room were observed with multiple large areas of chipped and scraped paint. The wall next to the dining room was observed with uneven plaster around the pull station and adjacent door frame. The conference room windowsills were observed with peeling, dirty duct tape that was hanging, and a ripped window shade. On 08/26/2025 12:58 PM, the Environmental Director was interviewed and stated they do environmental rounds and every now and then they assign one of their staff to paint and plaster. The Director of Maintenance stated they are aware of the chipped paint and are thinking to put a vinyl covering on doors to prevent this. The pull station became loose and was plastered a week ago and it will be sanded down. The Director of Maintenance also stated they were unaware of the ripped shade and hanging duct tape in the conference room. 2). On 08/19/2025 at 11:16 AM, room [ROOM NUMBER] was observed with multiple missing slats from the vertical blinds. On 08/19/2025 at 11:16 AM, in room [ROOM NUMBER] the vertical blinds were observed with 11 out of 20 slats missing. On 08/20/2025 at 10:44 AM, the Unit 2 dining room window was observed missing a window covering and the adjacent wall was unevenly plastered and unpainted. (continued on next page)

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	On 08/21/2025 at 12:32 PM, room [ROOM NUMBER] was observed with multiple missing slats from the vertical blinds, and the vertical blinds in room [ROOM NUMBER] were observed with 9 out of 20 slats missing. On 08/21/2025 at 12:33 PM, in room [ROOM NUMBER] there was peeling paint, a cracked window and the ceiling above B bed was observed with brown stains. 3). On 08/19/2025 at 1:52 PM and on 08/21/2025 at 12:57 PM, room [ROOM NUMBER] was observed with missing slats on the vertical blinds, and an air conditioner grill that was dirty and attached to the unit with paper tape, and the television remote did not work properly. The Unit 4 Maintenance book documented the following for room [ROOM NUMBER]: 6/17/2025-TV, check table, 6/19/2025-blinds missing, 6/24/2025- Bed table + remote 7/27/2025-check A/C. On 08/21/2025 at 12:57 PM, the resident who resided in room [ROOM NUMBER] was interviewed and stated the issues continue to persist and they have complained to the staff several times and at times when staff comes to the room to make repairs, they state they will return but never return to make the repairs. On 08/25/2025 at 9:18 AM, observations of the rooms on Unit 2 and Unit 4 that were identified with environmental issues were conducted with the Environmental Director. The Environmental Director was then interviewed and stated the black stain on the ceiling in room [ROOM NUMBER] is moisture from the rain coming through the bricks which was previously painted and plastered but they had no documentation of the repair. The Environmental Director also stated they were unaware of the cracked window in room [ROOM NUMBER] and they and the maintenance and housekeeping staff perform rounds in every room daily and they must have missed the needed window repair. The Environmental Director further stated the multiple missing vertical blind slats in residents' rooms is unacceptable, however the residents pull the slats out individually and they have to be replaced. On 08/25/2025 at 9:34 AM, an observation of room [ROOM NUMBER] was performed with the Environmental Director. The Environmental Director was then interviewed and stated that they knew the air conditioner grill in room [ROOM NUMBER] was held up with tape but they are ordering new grills and are working on replacing the cracked and missing vertical blinds slats. On 08/25/2025 at 4:01 PM, an interview was conducted with the Administrator who stated that they make rounds regularly and did not notice the missing vertical blinds were a trend but when they have noticed the missing blinds and other issues maintenance was contacted immediately to make repairs. 10 NYCRR 415.5(h)(2)